AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

OVERSIGHT OF TAX LAW RELATED TO HEALTH INSURANCE

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

APRIL 23, 1998

Serial 105–54

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
51–827 CC WASHINGTON : 1999

COMMITTEE ON WAYS AND MEANS

BILL ARCHER, Texas, *Chairman*

PHILIP M. CRANE, Illinois
BILL THOMAS, California
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
JIM BUNNING, Kentucky
AMO HOUGHTON, New York
WALLY HERGER, California
JIM McCRERY, Louisiana
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
PHILIP S. ENGLISH, Pennsylvania
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska
WES WATKINS, Oklahoma
J.D. HAYWORTH, Arizona
JERRY WELLER, Illinois
KENNY HULSHOF, Missouri

CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ROBERT T. MATSUI, California
BARBARA B. KENNELLY, Connecticut
WILLIAM J. COYNE, Pennsylvania
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
RICHARD E. NEAL, Massachusetts
MICHAEL R. McNULTY, New York
WILLIAM J. JEFFERSON, Louisiana
JOHN S. TANNER, Tennessee
XAVIER BECERRA, California
KAREN L. THURMAN, Florida

A.L. SINGLETON, *Chief of Staff*
JANICE MAYS, *Minority Chief Counsel*

SUBCOMMITTEE ON OVERSIGHT

NANCY L. JOHNSON, Connecticut, *Chairman*

ROB PORTMAN, Ohio
JIM RAMSTAD, Minnesota
JENNIFER DUNN, Washington
PHILIP S. ENGLISH, Pennsylvania
WES WATKINS, Oklahoma
JERRY WELLER, Illinois
KENNY HULSHOF, Missouri

WILLIAM J. COYNE, Pennsylvania
GERALD D. KLECZKA, Wisconsin
MICHAEL R. McNULTY, New York
JOHN S. TANNER, Tennessee
KAREN L. THURMAN, Florida

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Ways and Means are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

OVERSIGHT OF TAX LAW RELATED TO HEALTH INSURANCE

THURSDAY, APRIL 23, 1998

House of Representatives,
Committee on Ways and Means,
Subcommittee on Oversight,
Washington, DC.

The Subcommittee met, pursuant to notice, at 1:07 p.m., in room B–318, Rayburn House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON OVERSIGHT

FOR IMMEDIATE RELEASE
April 16, 1998
No. OV–15

CONTACT: (202) 225–7601

Johnson Announces Hearing on Oversight of Tax Law Related to Health Insurance

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Oversight of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on oversight of current tax law related to health insurance. The hearing will take place on Thursday, April 23, 1998, in room B–318 Rayburn House Office Building, beginning at 1:00 p.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Under the Internal Revenue Code, employees are not taxed for the benefits they receive in the form of employer-provided health insurance coverage, and employers can deduct the cost of providing the coverage. A portion of health insurance premiums paid by self-employed individuals is also deductible.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (P.L. 99–272), as amended, requires employers with 20 or more employees, who provide health insurance plans, to offer continued access to group health insurance to qualified beneficiaries generally for up to 18 months (in some cases for longer periods of time) if the beneficiaries lose coverage under the plan as a result of a qualifying event, such as termination of employment (other than for gross misconduct).

The Health Insurance Portability and Accountability Act of 1996 (P.L. 104–191) includes tax provisions related to health coverage portability, increasing the deduction of health insurance costs for the self-employed, establishing a deduction for employer-provided long-term care insurance, and Medical Savings Accounts.

Other tax-law provisions related to health insurance include cafeteria plans and flexible spending arrangements, itemized deductions for medical expenses, the use of excess pension assets to fund retiree health benefits, and several provisions related to long-term care.

In announcing the hearing, Chairman Johnson stated: "The deductibility of employer contributions to employee health insurance plans has been a significant factor in providing coverage to American workers. Over 65 percent of the non-elderly receive employment-based coverage. We need to examine the tax incentives that are currently in place to determine whether we can do more."

FOCUS OF THE HEARING:

The hearing will examine the operation of current tax law related to health insurance, and in particular, the effectiveness of the employer deduction for health care for employees, the COBRA health care continuation rules, and the premium deduction for the self-employed.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) single-space legal-size copies of their statement, along with an IBM compatible 3.5-inch diskette in ASCII DOS Text or WordPerfect 5.1 format only, with their name, address, and hearing date noted on a label, by the close of business, Thursday, May 7, 1998, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Oversight office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on an IBM compatible 3.5-inch diskette in ASCII DOS Text or WordPerfect 5.1 format. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS__MEANS/'.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman JOHNSON [presiding]. The meeting will come to order. It is a pleasure to welcome you here today.

The tax provisions in current law relating to health care are short on consistency and more importantly, short on fairness. This is hardly surprising, given the history of health insurance in this century. But with so many working Americans without health insurance coverage, it's a cause for great concern.

Before the thirties, few health insurance plans existed. Fully 90 percent of the medical expenses were paid out of pocket. During the Great Depression, as an increasing number of people were unable to afford medical care, hospital-sponsored health insurance arrangements were created.

By the late thirties, commercial insurers were offering comprehensive and major medical plans. In the forties, wartime price stabilization policies capped wages. Consequently, employers could not increase wages, but were often willing to increase compensation by providing more generous benefit packages, including health insurance, to attract employees. Unlike wages, compensation in the form of health insurance was a tax-free benefit.

As a result, today's health insurance system is based primarily on employer-provided coverage with several public programs filling in some of the gaps in coverage.

Over the years, the Tax Code has been amended, as the Nation's health insurance system has evolved. In 1943, the IRS ruled that employer contributions to group health insurance policies were not taxable to the employee. In 1953, the Service ruled that employer contributions to individual health insurances were taxable, a decision overturned when Congress enacted section 106 in 1954.

ERISA, the Employee Retirement Income Security Act, adopted in 1974, and the Revenue Act of 1978 established the rules for cafeteria plans. The health care continuation rules known as COBRA, the Consolidated Omnibus Budget Reconciliation Act, were enacted in 1985. A provision for a deduction for health insurance costs for the uninsured was added by the 1986 Tax Reform Act, and broadened most recently by HIPAA, the Health Insurance Portability and Accountability Act. HIPAA also provides limitations on preexisting condition exclusions and favorable tax treatment for long-term care coverage and for medical savings accounts.

Considered in isolation, all these provisions made good sense. Yet millions of Americans are paying their own health insurance premiums without the tax breaks available for employer-provided coverage, or for the self-employed. And millions more are unable to afford insurance at all.

I have given a great deal of thought to how to go about making these tax provisions fairer, more consistent, and rational. The Tax Fairness for Health Consumers Act, which I have introduced this spring, would be one step in the right direction. My legislation would address the inequities that exist in our current system by giving individuals the same health insurance tax benefits that the self-employed enjoy.

Congress provided tax deductibility for employer-subsidized health plans to encourage employers to offer coverage. We should do no less for the millions of Americans who are not fortunate enough to have health coverage through their employers.

My legislation also builds on the portability provisions established in HIPAA by making COBRA coverage deductible. It also would build on the long-term care tax incentives established in the HIPAA Act by allowing individuals who purchase long-term care policies to deduct the costs of these policies.

This hearing is an opportunity to review the effects of current tax law on health care coverage. With the information we gather today, we can better understand how to improve the Tax Code to provide broader access to health coverage.

Before hearing from the first panel, I'd like to yield now to my Ranking Member, Mr. Coyne.

Mr. COYNE. Thank you, Mrs. Johnson. And I want to thank you for scheduling this hearing here today. The growing number of working families without health insurance is of serious concern to us all. I am pleased that our Subcommittee has this opportunity to discuss the problem and some of the possible solutions.

In my home State of Pennsylvania, 1.2 million people do not have health insurance. Over one-quarter of a million of them are children. Last year, Congress took an important step toward providing insurance coverage for children by creating CHIP, the Children's Health Insurance Program. We can accomplish even more if we aggressively seek those uninsured children who qualify for assistance.

However, 86,000 of the uninsured children in Pennsylvania, and a comparable number of uninsured children in other States, do not qualify for any health insurance assistance. We must look for ways to help all of those children.

We must also help uninsured adults. Most of them work full time but are unable to afford private insurance or the insurance offered by their employers.

The purpose of this hearing is to discuss the effectiveness of current tax benefits designed to help people obtain health insurance. Tax deductions and income tax exclusions are certainly one way to approach the problem. Federal tax benefits currently finance 15 to 40 percent of the cost of health insurance for workers with employer-provided health benefits and for the self-employed.

But no similar benefit exists for employees who must purchase their own insurance or cannot afford the health insurance offered by their employers.

As we consider legislation to help more families afford health insurance, we must understand that additional tax deductions will not provide the whole solution to the problem. Two-thirds of the uninsured earn twice the poverty level or less. That's about $15,000 for an individual, or $32,000 for a family of four. Many of those working families have little or no tax liability. A tax deduction will not help them very much. Out-of-pocket costs like high deductibles and coinsurance payments are also a serious problem for families trying to afford health care.

Our Subcommittee should also consider whether encouraging uninsured families to buy insurance on the open market is the best solution. The Commonwealth Fund has estimated that individual insurance policies are 20 percent more expensive than employer-sponsored group plans, which take advantage of larger risk pools.

In conclusion, over 40 million Americans lack health insurance. Many more struggle to pay the deductibles and coinsurance required by their health plans. While recent data shows that more employers, including small businesses, are providing health benefits each year, the number of uninsured people continues to increase.

I look forward to hearing suggestions from the witnesses here today and from my colleagues about how this trend might be reversed. As we consider this problem, we need to keep in mind who the vast majority of the uninsured are and focus on solutions that will help as many people as possible.

Thank you.

Chairman JOHNSON. Thank you, Bill.

The first panel, please. Hon. Willis Gradison. Welcome, Bill, it's always a pleasure to have you with us. I'd like to offer a special welcome to Hon. George Reider, the Commissioner of Insurance from the State of Connecticut. I appreciate your being here, George. And Sal Risalvato from New Jersey, the owner of Riverdale Texaco and Precision Alignment Center. Thank you, welcome. It is a pleasure to have you.

Mr. Gradison.

STATEMENT OF HON. WILLIS D. GRADISON, JR., PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. GRADISON. Thank you very much for the opportunity to testify on behalf of the Health Insurance Association of America. It's always a privilege to appear before my former colleagues on this Subcommittee and a particular pleasure today to renew acquaintances with so many members of the staff who so ably serve Members on both sides of the aisle.

Despite vast changes in the private health care market and important State and Federal health care legislation passed during the last few years, there are still more than 41 million Americans without health insurance. That is why we are encouraged by the renewed interest in reducing the number of uninsured Americans by making health coverage more affordable.

I applaud you, Madam Chairman, for introducing H.R. 3475, which would allow individuals without employment-based health coverage to deduct the cost of health insurance premiums from their taxes. This important legislation underscores the need to make health care more affordable for more Americans. It would also provide greater equity in the tax treatment of health insurance between people who obtained coverage at their place of employment and people who purchase coverage in the individual health insurance market.

The private employment-based health care system has been tremendously successful in providing coverage to millions of Americans, even during times of rapidly increasing medical costs and swift improvements in medical treatment.

Since the Internal Revenue Service recognized in the early forties that employer contributions toward health insurance premiums were not taxable to employees, the number of people covered by group health insurance has grown from less than 12 million to approximately 150 million today.

Nonetheless, there are practical limitations to relying solely on the employment-based system to expand health coverage to uninsured Americans. Many people work for companies that do not offer health insurance or do not contribute to the cost of their employees' health coverage.

In addition, the over 12 million self-employed individuals currently may deduct only 45 percent of the cost of health premiums, and this will not reach full parity with larger firms under the current law until the year 2007.

For these reasons, we strongly support greater equity in the tax treatment of health insurance benefits for the self-employed and for individuals. We believe this goal can be accomplished by taking a balanced approach that builds on the strengths of the employment-based market, rather than undermining it. The employment-based system can and should work in tandem with a vibrant individual private health insurance market.

When considering options to make individual coverage more affordable, it is equally important that Congress avoid imposing onerous requirements on the fragile individual market. Because the purchase of insurance is voluntary, guaranteed issue, community rating, and other similar mandates drive up insurance costs and, consequently, reduce the number of people covered by private insurance.

For example, following the adoption of community rating and guaranteed issue requirements in New Jersey, average rates for the most popular individual indemnity health plans rose to more than double the national average for rates for similar coverage.

During 1996 alone, the number of people with individual coverage in New Jersey declined 17 percent, and the number of families covered declined 37 percent. We believe that State high-risk pools are a more responsible way to meet the needs of covering individuals with higher health costs.

Connecticut, for example, helps subsidize the cost of comprehensive medical benefits to about 1,200 high-risk individuals through a high-risk pool which caps rates for participants at 150 percent of standard premiums. These price caps work only when the necessary subsidy comes from broad-based sources.

Risk pools, however, will solve only a small part of the puzzle. The vast majority of individuals without health coverage are not in poor health. The key to expanding private health coverage to these individuals is to make coverage more affordable by extending tax equity or direct subsidies to the individual purchasers.

Madam Chairman, the legislation you have introduced to allow individuals without employment-based coverage to deduct the cost of health insurance would help to achieve this goal. H.R. 3475 builds on the employment-based framework to gradually increase deductibility for individuals, rather than requiring that policies qualifying for the deduction include benefits mandated by the government.

We are pleased that you have chosen to allow private market flexibility and innovation. We are also pleased that your legislation enhances individuals' ability to fully deduct the cost of long-term care insurance premiums. And in our written testimony, we provided some specific examples of additional steps that could be taken in this area.

Similar legislation introduced by Senator Boxer would allow individuals to immediately deduct 100 percent of the cost of health insurance premiums subject to a $2,000 annual cap. It would also allow individuals to deduct health insurance premiums whether or not they itemize their deductions.

Because these two bills apply only to those individuals with tax liability, they are not the complete answer to the challenge of providing health coverage to all uninsured Americans. There are 24 million uninsured, over half of the uninsured, that have incomes below 200 percent of the poverty level. But the approach taken in both bills would help make coverage more affordable.

In conclusion, we support the use of broad-based State and Federal funding to subsidize the cost of health insurance for those who cannot otherwise afford it. We would also encourage Congress to consider tax credits, vouchers, and other subsidies as a means of making coverage more affordable for even more Americans. And we look forward to working with you and your colleagues on this Subcommittee.

Thank you.

[The prepared statement follows:]

Statement of Hon. Willis D. Gradison, Jr., President, Health Insurance Association of America

I appreciate the opportunity to testify today on behalf of the Health Insurance Association of America (HIAA). It is always a privilege to appear before my former colleagues on the Ways and Means Committee. HIAA is the nation's most influential advocate for the private, market-based health care system. Its 250-plus member companies provide health, long-term care, and disability-income coverage to more than 65 million Americans.

HIAA has a long history of support for market-based initiatives designed to expand access to health coverage. I want to commend you, Madam Chairman, for your continued dedication to these important issues. I also applaud you for introducing H.R. 3475, which would allow individuals without employment-based health coverage to deduct the cost of health insurance premiums. This important legislation underscores the need to make health care more affordable for more Americans and to begin providing greater equity in the tax treatment of health insurance whether people obtain their coverage at their place of employment or purchase coverage in the individual health insurance market.

Despite vast changes in the private health care market, state initiatives, and important bipartisan federal health care legislation passed during the 104th and 105th Congresses, there are still over 40 million Americans without health insurance. We are committed to working with Congress, and with the states, to preserve and improve the nation's private health care system and to expand opportunities for more Americans to purchase private health insurance coverage.

In the aftermath of the Clinton Administration's failed attempt to expand health care coverage to all Americans over four years ago, it appears once again that there is increasing bipartisan interest in addressing these issues. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarified the tax treatment of long-term care insurance, increased and accelerated the health insurance deduction for the self-employed, authorized the creation on a demonstration basis of tax-preferred medical savings accounts (MSAs), and made it easier for people to maintain health coverage when they change jobs. Last year, Congress attempted to expand health coverage for millions of uninsured children by committing more than $20 billion over five years to a new State Children's Health Insurance Program and to an expansion of the Medicaid program.

In addition to your legislation, Madam Chairman, Senator Boxer has introduced S. 1902, which also would allow individuals to deduct the cost of health insurance premiums under certain circumstances. It also has been reported that Chairman Archer is developing a broader legislative measure to make health care more affordable. Among other tax initiatives, Chairman Archer reportedly would more quickly accelerate the gradual increase in deductibility of health insurance premiums for the self-employed, create new tax breaks for individuals purchasing long-term care insurance, create tax incentives for small businesses to buy health insurance for their workers and dependents, and provide a more generous tax deduction for health insurance purchased by individuals who do not have access to health coverage through an employer-sponsored health plan.

The foundation for the current employer-based health care system was laid during the Second World War. In response to wartime wage controls put in place to prevent companies from raising wages, employers began offering more generous health insurance and other non-cash fringe benefits to their employees and deducting such costs as normal business expenses under section 162 of the tax code. In 1943, the Internal Revenue Service ruled that employer contributions toward premiums for group health insurance were not taxable to employees.

Passage of the Employee Retirement Income Security Act of 1974 (ERISA) helped make it easier in many respects for large, multi-state employers to manage their fringe benefits and further cemented the relationship by which millions of workers receive health benefits through employer-sponsored plans.

As a result of these changes, the number of people covered by group health insurance has grown from less than 12 million in 1940 to approximately 150 million today.

At the same time, a series of amendments beginning in the early 1980s increased the floor for individually deductible medical expenses from 3 percent of adjusted gross income to its current 7.5 percent. These reductions in tax benefits for individually paid premiums, among other factors, have contributed to a steep decline in the number of people insured through individual health insurance over the past two decades. Thirteen million people have individual coverage today compared with 36.1 million in 1978.

While the private employer-based health care system is firmly rooted in its historic past, it has been overwhelmingly successful in providing coverage to millions of Americans even during times of rapidly increasing medical costs and swift improvements in medical treatment.

Moreover, employer groups—particularly large employer groups—do a very good job of pooling health care risks, encouraging large percentages of employees and dependents to participate in their health plans, and spreading the costs of coverage among both healthy individuals and those that incur greater health costs. This pooling function is absolutely vital to maintaining a robust private market. In addition, administrative costs associated with group health insurance coverage generally are lower than for individual coverage. These facts, coupled with the favorable tax treatment of employer-sponsored coverage, have resulted in an employer-based structure that has been extremely successful in providing good health coverage to a large number of people in a relatively efficient manner. For example, the loss of revenue attributable to the employee exclusion has been estimated by the Joint Committee on taxation to be about $50 billion annually. That is a relatively efficient way to provide coverage to 150 million people when one considers that the Medicare program spends nearly four times as much to cover two-thirds fewer people.

Despite these many positive attributes of employer-provided health care, there are some practical limitations to relying solely on employer-based coverage to expand health coverage to more uninsured Americans.

Many people work for companies that do not offer health insurance or do not contribute to the costs of their employees' health coverage. One out of four employees between the ages of 18 and 64 is not covered by an employer-sponsored plan, either directly or as a dependent of another worker. This is particularly true of individuals who work for smaller firms. Half of the employees of firms with fewer than ten workers lack employer-sponsored coverage.

In addition, the 12.3 million self-employed individuals currently may deduct only 45 percent of the cost of health premiums and will not reach full parity with larger firms under current law until the year 2007. Forty-nine percent of uninsured workers are self-employed or work in firms with fewer than 25 employees.

The availability of tax incentives is a key determinant as to whether an individual will be insured. According to the Employee Benefit Research Institute, individuals who pay for health coverage with their own after-tax dollars are 24 times as likely to be uninsured as those with employer-provided coverage.

Today's changing workforce expectations and career patterns also increase the importance of maintaining a robust individual health insurance market. As you know, the nature of work itself is changing. The industrial revolution has given way to the information revolution. People entering the labor force today no longer expect to spend their entire career with one company. Employers are demanding more highly-skilled and more flexible workers. Many employees today are being asked—and in some cases are seeking—to take more personal responsibility for their own benefits.

For these reasons, the Health Insurance Association of America strongly supports greater equity in the tax treatment of health insurance benefits for the self-employed and for individuals. We believe this important goal can, and should, be accomplished by leaving in place the current employment-based market which is working so well for so many Americans. We believe that the employment-based system can work in tandem with a more vibrant individual private health insurance market.

In attempting to make coverage more affordable for more Americans by providing greater equity in the tax treatment of health benefits for individuals and the self-employed, we must be very careful to take a balanced approach that builds on the strengths of the employment-based market, rather than undermining it. Moreover, given rapid changes already underway in the market, a radical shift away from the current system (rather than supplementing employment-based system with a strengthened individual market) could be extremely disruptive and result in an increase in the number of uninsured.

It is equally important when considering options to make individual health coverage more affordable that Congress and state legislatures avoid the temptation to impose onerous requirements on the individual private health care market. Because the purchase of insurance is voluntary, and because of the small, fragile nature of the individual market, guaranteed issue, community rating, and other similar mandates drive up insurance costs and consequently reduce—rather than increase—the number of people covered by private health insurance.

For example, Congress wisely avoided imposing individual market rating requirements when it guaranteed certain individuals who lose group coverage access to individual coverage under HIPAA. While a recent General Accounting Office (GAO) report found that HIPAA-eligible individuals were charged as much as 400–600 percent of standard premiums in four states where HIPAA's federal "fallback" mechanism has gone into effect, we have not seen evidence of comparable rates for these individuals in the 22 states that have adopted high-risk pools. Connecticut, for example, helps subsidize the cost of comprehensive medical benefits to about 1,500 high risk individuals through a high-risk pool which caps rates for participants at 150 percent of standard premiums. Such price caps may be tenable only when the necessary subsidy comes from general tax revenues or other broad-based funding sources, as is the case in state-created high-risk pools.

Nonetheless, Senator Kennedy and Representative Pallone have introduced legislation (S. 1804/H.R. 3538) that would cap rates for individuals eligible for coverage under HIPAA at 150 percent of standard premiums, regardless of whether a state has adopted a mechanism to spread risks beyond the fragile individual health insurance market.

A peer-reviewed actuarial analysis conducted by HIAA found that the Kennedy/Pallone legislation would raise costs an average of 10.9 percent for roughly 5.5 million Americans and cause nearly 160,000 people to lose coverage. States that have enacted guaranteed issue and some form of community rating in their individual health insurance markets have experienced similar consequences—significant increases in the price of indemnity insurance options, and significantly fewer people covered in the individual market. For example, following the adoption of community rating and guaranteed issue in New Jersey in 1993, average rates for the most popular individual indemnity health plans rose to more than double the national average of rates for similar coverage. During 1996 alone, the number of people with individual coverage in the state declined 17.2 percent, and the number of families covered declined 37 percent.

Experience clearly shows that, in attempting to expand health coverage to high-risk individuals, it is vital to provide a broad-based subsidy to offset additional costs, as in the risk pool model that has worked successfully in 22 states. Arbitrarily imposed price controls ignore the need for responsible funding of these costs, and threaten the very market we are relying on to provide coverage.

Risk pools, however, will solve only a small part of the puzzle. The vast majority of individuals without health coverage are not in poor health. A 1994 Kaiser Family Foundation report, for example, asked uninsured individuals the primary reason they did not have insurance. Only three percent of respondents reported that they were uninsured because they had difficulty obtaining coverage due to ill health or prior illness, compared with 59 percent who indicated they could not afford health coverage. The key to expanding private health coverage to these individuals is to make coverage more affordable by extending tax equity or direct subsidies to individual purchasers.

Madam Chairman, the legislation you have introduced to allow certain individuals without employment-based coverage to deduct the cost of health insurance would help begin to achieve this goal. H.R. 3475, which would gradually increase individual deductibility from 45 percent to 100 percent in 2007, has the virtue of building on the current deductibility framework for the self-employed. HIAA also is pleased that you have chosen to build on the current definition of medical care expenses under the tax code and allow private market flexibility and innovation, rather than requiring that policies qualifying for the deduction include benefits mandated by the government.

We also are pleased that your legislation enhances individuals' ability to fully deduct the cost of long-term care insurance premiums. Incentives for the purchase of long-term care insurance were included in HIPAA. As a result, a new federal focus on streamlining public expenditures and encouraging individual responsibility has emerged. Nevertheless, HIPAA is not a panacea and will not, by itself, achieve the optimum public-private partnership for long-term care financing. HIAA believes that other equally important tax-related changes, at both the federal and state levels, could make long-term care insurance more affordable to a greater number of people. The expansion of this market will restrain future costs to federal and state governments by reducing Medicaid outlays.

Providing additional tax incentives for these products would reduce the out-of-pocket cost of long-term care insurance for many Americans, would increase their appeal to employees and employers, and would increase public confidence in this relatively new type of private insurance coverage. In addition, it would demonstrate the government's support for and its commitment to the private long-term care insurance industry as a major means of helping Americans fund their future long-term care needs.

Some examples of additional specific actions that could be taken are to:

- Permit the tax-free use of IRA and 401(k) funds for purchases of long-term care insurance;
- Permit long-term care premiums to be paid through cafeteria plans and flexible spending accounts;
- Provide a tax credit for the purchase of long-term care insurance; and
- Encourage state tax incentives for the purchase of long-term care insurance.

These tax incentives would largely benefit two groups: those who did not have the opportunity to purchase such coverage when they were younger and the premiums were lower and, as a result, now face the greatest affordability problems because of their age; and those younger adults, our current baby boomers, who need incentives or mechanisms to fit their own long-term care protection into their current multiple priorities (e.g., mortgage and children's college tuition) and financial and retirement planning.

Finally, it is unclear from our initial reading whether H.R. 3475 is intended to allow individuals to deduct Medicare supplemental premiums, or premiums associated with private health plans available through the Medicare+Choice program. The HIAA fully supports extending individual tax deductions to these policies and believes that the bill's language should be clarified in this regard to explicitly allow such deductions.

Legislation introduced by Senator Boxer (S. 1902) similarly would allow individuals to deduct the cost of health insurance premiums. The legislation is more expansive than H.R. 3475 in three key respects. First, it would allow individuals to immediately deduct 100 percent of the cost of health insurance premiums subject to a $2,000 annual cap. Second, it would allow individuals to deduct health insurance premiums whether or not they itemize their deductions. Finally, the legislation appears to allow employees to deduct their portion of health care premiums even if their employers offer and contribute toward their coverage. This last provision may help provide an important incentive for uninsured individuals who, with increasing frequency, now decline coverage offered by their employer according to a February 1998 study by the Lewin group. Unlike H.R. 3475, however, Senator Boxer's legislation would not allow individuals to deduct long-term care insurance premiums.

Because H.R. 3475 and S. 1902 apply only to those individuals with tax liability, they are not the complete answer to the challenge of providing health coverage to all uninsured Americans. Twenty-four million uninsured Americans—over half of the uninsured—have incomes below 200 percent of the federal poverty level. But the approach taken in both bills will help make coverage more affordable for many working Americans who are not currently covered by health insurance through their place of employment. Equally important, both pieces of legislation rely on the private insurance market rather than expanding the reach of government programs. Also, they will begin to close the tax equity gap between those who get health insurance at work and those who do not.

In conclusion, HIAA supports the use of broad-based state and federal funding to subsidize the cost of health insurance for those who cannot otherwise afford it. We have witnessed the success of favorable tax treatment in helping to expand coverage to a large percentage of working Americans. Therefore, we believe that providing greater equity under the tax code for individuals and the self-employed is a reasonable way to make health coverage more affordable for a large number of the 41 million Americans who currently do not have coverage. H.R. 3475 and other similar measures would be a very good start. We also would encourage Congress to consider tax credits, vouchers and other subsidies as a means of making coverage more affordable for even more Americans.

Again, we are encouraged that Congress is returning to the issue of the uninsured and considering ways to make private health coverage more affordable. We look forward to working with you as you consider ways to expand private health coverage and provide equitable treatment under the tax code for individuals who have taken responsibility for their own health care coverage.

Chairman JOHNSON. Thank you very much, Bill.

George Reider.

STATEMENT OF HON. GEORGE M. REIDER, JR., COMMISSIONER OF INSURANCE, STATE OF CONNECTICUT; AND VICE PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mr. REIDER. Thank you very much. Good afternoon, Madam Chairman, Members of the Subcommittee. My name is George Reider. I am commissioner of insurance for the State of Connecticut. I am also vice president of the National Association of Insurance Commissioners. I am testifying today on behalf of the NAIC's Special Committee on Health Insurance. I appreciate the opportunity to testify.

Today I will focus on the States' effort to implement the Health Insurance Portability and Accountability Act of 1996, known as HIPAA. I will discuss briefly the effect of Federal tax proposals on the implementation of HIPAA.

I have three points to discuss. First and most important, most States have successfully implemented HIPAA. Second, some people eligible for HIPAA's protections in the individual health insurance market are being charged very high premiums, and this is a problem. Third, it may be difficult to measure the impact of Federal tax proposals to increase the affordability of individual health insurance.

We are proud to report today that 46 jurisdictions have implemented the key requirements of HIPAA. All but five States have now acted. Earlier this month, Kentucky enacted HIPAA legislation. This represents a significant achievement for the States, especially given the complexity of the statute and the short timeframe for implementation that it imposed.

There has been considerable attention focused on the five States that have not enacted HIPAA legislation. They are Missouri, California, Rhode Island, Massachusetts, and Michigan. The decision of the legislatures in these States not to act has complicated the implementation of HIPAA. But we do wish to emphasize that in four of these five States, there are State laws that provide some of HIPAA's protections.

State insurance departments in these States are continuing to enforce State law for the benefit of consumers and to regulate the health insurance industry.

In Connecticut, we modified our existing high-risk pool, the Health Reinsurance Association, HRA, to implement HIPAA's requirements for the individual health insurance market. The HRA has issued 40 policies to HIPAA-eligible individuals so far this year, including 14 to low-income individuals.

I would like now to address the issue of health insurance affordability. The high cost of the policies offered to many HIPAA-eligibles is a problem. We commend the Chair for her concern about this issue as expressed in the tax legislation that she introduced, H.R. 3475.

The NAIC commented on the high premiums charged to some HIPAA-eligibles in testimony last September before the Health Subcommittee of the House Ways and Means Committee. We also discussed this in March before the Labor and Human Resources Committee.

This is particularly a problem in States where the so-called Federal fallback standards are in effect and certain other States as well. Some carriers are segregating HIPAA-eligibles from other individuals and rating them separately. This is one cause of the high cost of health insurance for these individuals.

We believe that the language of HIPAA is adding to this problem in the individual health insurance market. The law does not explicitly impose restrictions on the premium rates that carriers may charge to people eligible for HIPAA's protections, and there is a critical omission in the statute. My written testimony provides further details about this problem.

You have asked us to comment on Federal tax proposals relating to health insurance. One issue is whether expanding the deductibility of health insurance premiums to more individuals might help them to afford insurance. I cannot comment on this issue for the NAIC, because our expertise is the regulation of insurance and not Federal tax policies.

But I can comment on the potential difficulty of measuring the impact of these tax proposals, especially on HIPAA-eligibles. In most States, it is not easy to identify how many people are covered by individual health insurance policies, nor is there much information about how many people qualify for HIPAA in the individual market.

Connecticut and other States do have some information about the number of HIPAA-eligibles who are participating in the State's high-risk pool or who have purchased commercial insurance. But we do not know how many people eligible for protections under HIPAA have not exercised their right. This is the number that must be identified to measure the impact of H.R. 3475.

It is likely that many people cannot afford the high cost of coverage available to them under the law. The process of implementing HIPAA has just begun. State insurance departments are making every effort to ensure that the requirements of the Federal law are implemented and consumers receive the protection the law creates. But much work remains to be done to achieve HIPAA's full potential.

Madam Chairman, on behalf of the members of the NAIC, I would like to thank you and the Subcommittee once again for the opportunity to testify today, and I will be happy to answer any questions. Thank you.

[The prepared statement follows:]

Statement of Hon. George M. Reider, Jr., Commissioner of Insurance, State of Connecticut; and Vice President, National Association of Insurance Commissioners

INTRODUCTION

Good afternoon, Madam Chairwoman, and members of the Subcommittee. My name is George Reider, and I am the Commissioner of Insurance of the State of Connecticut. I am also the Vice President of the National Association of Insurance Commissioners (NAIC).

The NAIC, founded in 1871, is the organization of the chief insurance regulators from the 50 states, the District of Columbia, and four of the U.S. territories. The NAIC's objective is service to the public by assisting state insurance regulators to fulfill their regulatory responsibilities. Protection of consumers is the fundamental purpose of insurance regulation.

I am testifying today on behalf of the NAIC's Special Committee on Health Insurance, of which I am the Vice Chair. This NAIC Committee is composed of 41 state insurance regulators and was established as a forum for NAIC members to respond to Congressional and federal requests for technical assistance.

On behalf of the NAIC Committee, I would like to thank you for the opportunity to testify today on how proposed tax legislation would affect the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It is a privilege to appear before this Subcommittee.

My testimony this afternoon will focus on the efforts of the states to implement HIPAA. I have three major points to share with you today. First, most states have successfully implemented HIPAA. In four of the five states that have not chosen to enact legislation implementing HIPAA, there are existing state laws that provide consumers with some of the same protections. Second, the high cost of the individual health insurance policies available to persons who qualify for HIPAA's protection in the individual market (HIPAA-eligibles) is a problem which we have raised in prior testimony, and which I explain below. Third, it may be difficult to measure the impact of proposed tax legislation, such as H.R. 3475, because of the scarcity of data about HIPAA-eligibles and about the individual health insurance market.

I. MOST STATES HAVE SUCCESSFULLY IMPLEMENTED HIPAA

Since HIPAA's enactment in 1996, 46 jurisdictions have implemented the statute's major provisions: the guaranteed issuance and renewability of all products in the small group insurance market; the implementation of federal standards or an alternative mechanism in the individual insurance market; limiting the permissible periods of exclusion for preexisting conditions in the group market; and requiring credit for prior coverage in the group market.

This represents a significant achievement for the states, especially given the deadlines imposed by HIPAA and the complexity of the statute. It is due in part to the recognition by Congress, as expressed in the federal law, that many states had already enacted significant reforms in the small group and individual insurance markets. HIPAA builds upon these state laws, and in general, allows them to stand unless they interfere with a requirement of the federal law. Members of Congress are to be congratulated for their hard work in making certain that HIPAA narrowly limited its preemption of state law.

Substantial attention has been focused on the five states that have not yet implemented HIPAA: Massachusetts, Rhode Island, Michigan, California, and Missouri. In testimony given before the Senate Committee on Labor and Human Resources on March 19, 1998, we provided information about the situation in each of these five states. I would like to share that information with this Subcommittee.

Massachusetts enacted small group reforms in 1991. Then Massachusetts enacted extensive legislation in the summer of 1996, just before HIPAA's passage, that reformed its individual market, including guaranteed availability of coverage without any preexisting condition exclusions. The individuals who qualify for guaranteed availability must meet certain criteria, but these are generally the same or more generous than HIPAA's requirements. At the same time, Massachusetts passed some portability reforms for its large group market. In concept therefore, the law in Massachusetts is similar to HIPAA's requirements in many areas, and in some situations provides greater protections, but does not address all of HIPAA's requirements. For example, a broader base of people have access to coverage in the individual market than under HIPAA; however, Massachusetts law defines small groups differently from HIPAA and does not address certifications of coverage. In addition Massachusetts does not provide for guaranteed renewability in the individual market to the same extent as HIPAA. The lack of specificity on how and when the federal government will regulate and when it will not is causing market concern for carriers and consumers.

Rhode Island state law also contains significant portability rules. Under Rhode Island law, any individual who has had twelve months of uninterrupted coverage cannot be subjected to any period of exclusion for preexisting conditions. This rule applies regardless of whether an individual is moving from group to group coverage; from individual to individual coverage; from group to individual coverage; or from individual to group coverage. This feature of Rhode Island law provides greater protection than HIPAA. However, because it requires an individual to have had twelve months of uninterrupted coverage and to move immediately to new individual coverage, Rhode Island's law is more stringent than HIPAA. (The federal statute allows periods of interrupted coverage to be aggregated if the gap between periods of coverage does not exceed 63 days.) In addition Rhode Island has a small group law that offers many of the protections of HIPAA.

Consumers in Michigan have excellent access to the individual market because Michigan Blue Cross and Blue Shield (MBCBS) is required by law to offer individual coverage to any Michigan resident. The Blues offer a choice of seven individual plans, and these are priced pursuant to pure community rating. Individuals are, however, subject to a six-month exclusion for preexisting conditions. But individuals who are converting from a group plan that MBCBS either underwrites or administers are *not* subject to a new preexisting condition waiting period. Because MBCBS represents over half the Michigan insured market, this protection applies to a substantial number of people.

In the small group market, Michigan law requires guaranteed renewability and uses the HIPAA definition of preexisting condition. MBCBS is required by law to cover everyone, and this requirement applies to the large group, small group, and individual markets.

California also has in place certain laws that are comparable to HIPAA. For the most part, California state law regulating the small group insurance market complies with HIPAA's small group requirements. In California, the insurance department staff continues to respond to consumer complaints and inquiries about individual coverage. The insurance department staff refers to the Health Care Financing Administration (HCFA) any cases that they cannot resolve with the carrier, but makes every effort to assist consumers before taking that step. In California, the Department of Corporations has jurisdiction over HMOs. The staff of this department are also making every effort to assist consumers before referring them to HCFA.

Missouri's Director of Insurance reports the following information about Missouri, which was the first state to notify HCFA that it would not be enacting HIPAA legislation. Missouri already has a state statute that guarantees issue of two products in the market of three to twenty-five, but it does not effectively regulate rates, and very few policies have been issued under it. In addition, Missouri has no law guaranteeing issue of any product in the individual market, or in the market of twenty-six and over. The HIPAA minimum standards therefore significantly exceed Missouri state law. The Missouri Department of Insurance and HCFA have been coordinating their efforts for almost a year, and both report excellent cooperation. The Department of Insurance attempts to handle all complaints initially and then refers some to HCFA. Dual enforcement in this state means that carriers submit dual filings of the product forms for review and approval.

I have provided detail about these situations to dispel any misconception that consumers in four of these states have no protections and that carriers have been left unregulated. While the fact that the legislatures in these states did not address HIPAA in 1997 has complicated the implementation of the statute in the short-term, the state insurance departments are monitoring the situation and enforcing their own state laws. The existing laws and regulations in four of these states significantly address HIPAA's goals of providing credit for prior health insurance coverage and increasing access to coverage for individuals and small groups.

I would also like to update this Subcommittee on the situation in Kentucky. Under HIPAA, Kentucky was granted a statutory deadline of July 1, 1998, because its legislature did not meet in regular session in 1997. I am pleased to report that the Kentucky legislature has now enacted HIPAA legislation incorporating in state law the federal fallback standards for the individual health insurance market.

I would now like to explain my own state's approach to HIPAA implementation. Connecticut amended its laws in 1997 to utilize its existing high risk pool as an alternative mechanism to provide health insurance without preexisting condition exclusions to all HIPAA-eligible individuals. Policies, including a special health care plan for low-income individuals, are available directly from the Health Reinsurance Association (HRA).

HRA plans provide benefits that are comparable to group plans available to small employers under Connecticut's small employer legislation. Premiums for HRA plans may not exceed 150% of average group rates in the state, and pool losses are assessed to member insurers and HMOs.

Prior to the HIPAA amendments, the HRA had provided conversion plans without a waiting period for preexisting conditions to applicants who had been insured under an employer group plan for 12 months or more and whose coverage, including any COBRA continuation, had terminated.

Because of the HIPAA changes, individuals who have been covered under self-insured plans may also be eligible for immediate coverage, without a waiting period. Self-insured employers, however, have declined to participate in the HRA pool, citing federal preemption under the Employee Retirement Income Security Act of 1974 (ERISA).

The HRA has issued about 40 policies to HIPAA-eligible individuals this year, including 14 special health care plans. It is not known how many of these people would in any case have been eligible for conversion policies.

In addition to providing insurance for persons formerly covered under group plans, HRA offers individual health insurance regardless of health status to any state resident, subject to preexisting condition waiting periods. HRA was established under state legislation in 1975.

II. The Language of HIPAA Contains Omissions and Ambiguities that Have Complicated Its Implementation in the Individual Health Insurance Market

A recent report of the General Accounting Office, Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators (GAO/HEHS–98–67) (the GAO Report), mentions some of the problems that have arisen in the initial months of HIPAA's implementation. The high cost of the individual policies offered to HIPAA eligibles by some carriers is one of the major problems. The NAIC commented on this issue in our testimony of September 25, 1997, before the Health Subcommittee of the House Ways and Means Committee, and in our testimony of March 19, 1998, before the Senate Committee on Labor and Human Resources. I would like to reiterate our concern and explain how the language of the statute itself is contributing to the problem.

In our testimony before the Health Subcommittee of the House Ways and Means Committee, we noted that HIPAA does not explicitly impose restrictions on the premium rates that may be charged to persons who qualify under the statute for guaranteed issue in the individual market. However, states may choose to establish a high risk pool that provides for premium rates and covered benefits that are consistent with the standards contained in the NAIC's Model Health Plan for Uninsurable Individuals Act. Another option for states implementing an alternative mechanism is to adopt either the NAIC's Small Employer and Individual Health Insurance Availability Model Act or the Individual Health Insurance Portability Model Act. Both of these models contain risk spreading mechanisms and rating restrictions to ensure that the rates charged to eligible individuals are controlled. Finally, states adopting any other type of alternative mechanism must ensure that the mechanism "provide[s] for risk adjustment, risk spreading, or a risk adjustment mechanism" and meets other criteria.[1]

These provisions suggest that Congress did not intend carriers to classify HIPAA-eligible individuals separately from others in the individual market and charge them higher premiums.

The ambiguity about restrictions on the premiums in the individual market is also contained in the HIPAA provisions containing the federal fallback standards. In states that do not implement an alternative mechanism, HIPAA permits carriers to limit their offerings to HIPAA-eligible individuals to a choice of either the two most popular policy forms or, in the alternative, to two policy forms with representative coverage.[2] The statutory language addressing the policy forms having representative

[1] PHSA § 2744(c), 42 U.S.C. § 300gg–44(c).
[2] PHSA § 2741(c), 42 U.S.C. § 300gg–41(c).

coverage explicitly requires them to be covered under a method of "risk adjustment, risk spreading, or financial subsidization." [3] The language addressing the two most popular policy forms lacks this language, presumably because Congress thought that the two most popular policy forms would always be subject to some method of risk adjustment.[4]

This omission has made it extremely difficult for states attempting to implement the federal fallback provisions to prevent carriers from segregating HIPAA-eligible individuals from the rest of the individual market and increasing their premiums based solely on the fact that these individuals are HIPAA-eligibles. It has created the potential for gaming by the industry with respect to the policy forms that they will offer HIPAA-eligibles. We think that HIPAA should be interpreted to prevent carriers from segregating HIPAA-eligibles from other purchasers of individual health insurance, and we would have liked Congress to be more explicit about this intent. Because of the fragility of the individual insurance market, any activities by carriers that fragment the market into two separate pools will make the cost of insurance prohibitive for some individuals and will enable carriers to comply with the law in a technical sense, but avoid having actually to insure HIPAA-eligible individuals.

In our testimony on March 17, 1998, before the Senate Committee on Labor and Human Resources, we stated that, for the fourteen jurisdictions in which the federal fallback standards in the individual market are applicable, the most important problem is the high cost of the individual policies offered to HIPAA-eligibles. It is also a problem for certain other states. We agree with the observation in the GAO report that the statute only imposes a risk-spreading requirement if a carrier chooses to offer two representative policies. If a carrier chooses instead to offer only its two most popular policies, or to guarantee issue all its individual products, HIPAA is silent about rating restrictions. At least four federal fallback states and at least two other states report this as an issue of major concern.

Regulators in some of the states where the federal fallback standards apply in the individual insurance market had hoped for more guidance from the federal government about the appropriate risk-spreading mechanism to be applied to the individual policies that carriers must guarantee issue. They had also hoped for more guidance in the federal regulations about certain key terms, such as "most popular policy form" and "representative policy forms." While the regulations define these terms, the definitions themselves raise additional questions.

We are aware of the difficult actuarial issues raised by the federal fallback provisions of HIPAA. The NAIC is working to assist HCFA to develop provisions in the final regulations that will provide appropriate guidance. We also recognize that the complexity of this task is caused in part by the ambiguity of the statute.

The ambiguity in the statute and the sparse guidance contained in the federal regulations have combined to create opportunities for gaming by carriers. They can manipulate both the content and the pricing of the policy forms that they offer to individuals. Some carriers impose automatic rate increases as high as 35% above standard rates on HIPAA-eligibles. This increase, or "rate up," is imposed simply because an individual qualifies for HIPAA. It does not include additional increases based on the individual's actual health status. This practice has helped cause the dramatically high prices for some policies made available to HIPAA-eligibles in some states.

III. The Success of Federal Tax Proposals Intended to Increase the Affordability of Health Insurance May be Difficult to Measure

Proposals to amend federal tax law to make health insurance more affordable are one approach to the difficult issue of the high cost of health insurance for HIPAA-eligibles and others. We commend the Chairwoman for her concern about this problem as expressed in the bill she has introduced, H.R. 3475, the "Tax Fairness for Health Consumers Act of 1998," which would make available to all individuals not eligible to participate in an employer-subsidized health plan the same tax deduction for their health insurance premiums as the self-employed currently receive.

I am unable to offer any official comments on H.R. 3475 or any federal tax proposals because the expertise of the members of the NAIC is the regulation of insurance, not federal tax policy. I therefore wish to make clear that my comments are not to be construed as the position of the NAIC. While it is a laudable goal to increase the affordability of health insurance, I would like to explain the limitations of existing health insurance data that complicate assessing the impact of these proposals.

[3] PHSA § 2741(c)(3)(A); 42 U.S.C. § 300gg–41(c)(3)(A).
[4] PHSA § 2741(c)(2); 42 U.S.C. § 300gg–41(c)(2).

In many states, it is not simple to define with precision the individual health insurance market. For example, in Connecticut we know that thirteen carriers have obtained the approval of the Insurance Department to sell individual health policies. We do not know how many people are covered by individual insurance policies, either as the purchaser of the policy or as a dependent of the purchaser. Nor do we know how many people in Connecticut are eligible under HIPAA to participate in Connecticut's alternative mechanism, which is its high risk pool (''Health Reinsurance Association'' (HRA)). We do know, as stated above, that Connecticut's high risk pool has issued 40 policies to HIPAA-eligibles so far in 1998, of which 14 are special health care plans for low-income individuals. It is not known how many of these people would have been eligible for HRA conversion policies in the absence of HIPAA. We also know that, as of March 17, 1998, Connecticut's high risk pool has issued approximately 1,224 policies, and that the number of policies issued has approximated 1200 for a number of years. The high-risk pool receives about 1,600 telephone inquiries per month from individuals, agents, and brokers. This number increased slightly in January 1998, when HIPAA went into effect.

Other states are attempting to collect data about the size of their individual insurance markets, and the number of HIPAA-eligibles in this market. For example, the Colorado Insurance Department surveyed all carriers in that state's individual market to determine the numbers and types of policies sold and to obtain other information. As of January 21, 1998, 125 HIPAA-eligible individuals had purchased commercial insurance, out of a total individual health insurance market consisting of approximately 152,357 covered lives. These 125 individuals do not include HIPAA-eligibles who have chosen to participate in Colorado's high risk pool rather than purchase commercial insurance. (In Colorado, there is a high risk pool, but the state did not choose to use the pool as its alternative mechanism under HIPAA.) It should also be noted that, for federal fallback states, any figures estimating the number of HIPAA-eligibles will often only reflect individuals whom carriers consider high risk HIPAA-eligibles. Others who qualify for HIPAA's protections are often sold standard individual policies, which are cheaper.

Arizona, another federal fallback state, is also in the process of surveying its individual carriers to determine the scope of the individual market and the number of HIPAA-eligibles.

The states that have chosen to implement a high risk pool as their alternative mechanism report varied numbers. For example, Pennsylvania reports that, as of March 23, 1998, 64 HIPAA-eligible individuals have enrolled in the state's alternative mechanism, which is operated by the Blue Cross and Blue Shield plans. In Indiana, three HIPAA-eligible individuals qualified for the state's high risk pool as of the end of 1997. These numbers are examples only, and are not based on a comprehensive survey.

Moreover, all these numbers reflect only the people who are both HIPAA-eligibles and who can afford to pay the premiums for commercial individual coverage or to participate in a high risk pool. We do not know the number of individuals who would exercise their HIPAA rights if cost were not an issue. This is the number that needs to be identified in order to measure the impact of H.R. 3475.

It is too soon to know whether these numbers of HIPAA-eligibles will increase over time. HIPAA has been in effect in the individual market only since July 1, 1997, in the federal fallback states, and only since January 1, 1998, in states that implemented an alternative mechanism.

IV. Conclusion

The process of implementing HIPAA has only begun. The states have made a tremendous effort to implement the law in a short time period, and they are working actively to ensure that consumers receive HIPAA's protections. However, it is a problem that the premiums charged to most HIPAA-eligibles for commercial insurance are very high, especially in states where the federal fallback standards are in effect. The NAIC has identified this problem in two previous Congressional testimonies and has also commented on the language of the statute that helps to create this situation. This lack of affordability makes HIPAA meaningless for many individuals who otherwise qualify for the statute's protections. We commend the Chairwoman for her concern about the issue of affordability of health insurance, but it is not within the area of expertise of the members of the NAIC to comment on the impact of H.R. 3475 or other federal tax proposals. There is not extensive information about the number of individuals who qualify for HIPAA's protections in the individual market.

Madam Chairwoman, once again, on behalf of the members of the NAIC Committee, I thank you for the opportunity to testify today. I hope that the information

I have provided about the states' implementation of HIPAA will assist as you consider proposals to help make health insurance more affordable. The NAIC members look forward to continuing to provide their technical expertise to you and to the 105th Congress on issues relating to HIPAA and health insurance generally.

Chairman JOHNSON. Thank you very much.

Mr. Risalvato.

Mr. RISALVATO. You've got it, Risalvato.

STATEMENT OF SAL RISALVATO, OWNER, RIVERDALE TEXACO & PRECISION ALIGNMENT CENTER, RIVERDALE, NEW JERSEY

Mr. RISALVATO. Madam Chairman and Members of the Subcommittee, thank you very much for inviting me here today. The subject we are here talking about today is one that I've come before Congress a number of times to discuss. Each time we get a little bit better. Sometimes we take a step back; sometimes we take a step forward.

I am here to discuss with you how this type of legislation and the deductibility of our health care premiums affect myself as a small business owner and other small business owners across our country.

I was very pleased in your opening statement when you sort of described a little bit of the previous history of where we've come with health insurance and who's paid for it and who's covered it.

The issue that we're talking about today—that's got its own little history. And I kind of got involved sort of as an advocate in the small business community somewhat because of this issue. When I first started to provide benefits for my employees as a small business owner, I had two mechanics that were working for me back in the early, mideighties, and they were good. And of course, as the owner of a small business, you want to know, are you competing with your pay to your employees as well as others. And I thought that I was, but you really can't get a good handle on that. Where's the gauge?

But the one thing I was certain of is that other garages were not providing health care benefits for their employees. So bingo, I had something that they didn't have and I started to provide those benefits for my employees. I did that because I'm competing in the marketplace, not just for customers, but for employees. So I did that, and that was a very good thing. And I then found out at the end of the year that I could not deduct part of that health care policy that I paid for myself.

Now I didn't do this as a tax writeoff; I did this as a benefit. But I learned about it after the fact, and I was very angry. But there wasn't anything I could do about it. And the original reason that I did it, it worked. I kept my employees and I had good employees and there are obvious benefits to that, because if I have better employees, I do more business. If I do more business, I make more profit. If I make more profit, I pay more taxes and I know you like that.

In 1986, after a number of years of complaining about it, Congress was kind enough to throw me a bone. Now, I don't mean that in any disrespectful term. But that's exactly what they did. Congress recognized that the small business community was being treated differently.

The chairman of the board of General Motors and Ford and all of the big Fortune 500 companies deduct the health care benefits for those persons in their employ, for the chairman of the board. And I ask you, am I not, in effect, the chairman of the board of my little subchapter S corporation? I am the chairman of the board. Why should I not be treated the same?

So in 1986, Congress throws me this bone and then sunsets it in 1989, which Congress never sunsets anything except they sunset this and I couldn't figure that out. And then every year made me come back and beg for another bone. And I'm a meat and potatoes guy; I like a lot of meat on my bone and I was getting no meat, just bone. But I was chewing on it.

That ran out in 1994 and I had to come back begging in 1995, and fortunately, we made it a permanent deduction. We increased that 25-percent deduction that was that bone that Congress gave me in 1986. We increased that to 30 percent and made it permanent for 1995.

And then in the course of these last few years, we have taken the deduction and we have continued its permanency and kind of phased it in over a bunch of years to the 100-percent level, which is actually fair; 100 percent is what is fair.

So that's where we've come from. Where we're at now is we have it and we're phasing it in and we've recognized it's fair for 100 percent. Now I'm asking you, please let's speed up the process. Ten years is a long time, and this dog ages 63 years over that lifetime for the meat on his bone.

I've recently spoken with a number of other small employers. I mean, people know that I'm involved in this issue. And they say that they don't provide any benefits even though they may have only one or two people working for them. They don't provide the benefits. But if they did, why should they provide them when they can't deduct them off of their own bottom line for what they purchase for themselves, only for what they purchase for somebody else? It's sort of senseless.

So I am asking you on behalf of the small business community of the United States, on behalf of myself, please speed up this process. It will help get more small business owners motivated to provide some sort of benefits for themselves and their employees and to take them off of the role of the health care deadbeat and take them out of this cost-shifting atmosphere.

This is something that makes sense. We believe Congress should have the funds available to manipulate to provide this for the small business community, and I respectfully ask that you seriously consider this and adopt it. Thank you.

[The prepared statement follows:]

Statement of Sal Risalvato, Owner, Riverdale Texaco & Precision Alignment Center, Riverdale, New Jersey

Good afternoon. My name is Sal Risalvato. Thank you Mr. Chairman for giving me the opportunity to explain to you what it is like to own a small business, and to endure the unfairness in our tax code. I am here to speak about the deduction for healthcare premiums paid by the owners of small businesses.

I am the owner of a small business. I own Riverdale Texaco, a gasoline service station in Morris County, New Jersey. I have been in the service station business since 1978.

As I am sure you know, until last year, Congress had treated the deductibility of healthcare premiums for small business owners like a YO-YO. The Health Insurance Portability Act of 1996 solved half of the problem and put some sense into the tax treatment of healthcare premiums by establishing a permanent deduction. The train is now on the right track. The only problem is the train is moving too slow.

I hope to accomplish several objectives today. First, I hope to make you understand the plain, simple, and obvious unfairness of the tax treatment of healthcare premiums as they relate to the owners of small business. Second, I would like you to understand how that treatment is working against any solutions in the reform of healthcare.

I first started to provide healthcare benefits for myself and my employees in 1981. Previously, I myself was not insured. I have always owned my own business from the day I graduated from high school. As a healthy, inexperienced youth, I was not yet wise enough to realize the dangers of being uninsured for serious illness. Had I gotten seriously ill while I was in my early twenties, I would have had no means of paying for my illness, thereby becoming one of those that burden the healthcare system. I am sure you are all aware of the term "cost shifting." Had I become seriously ill back then, I would have been guilty of "cost shifting."

I cannot say that it was a sudden rise in the level of my wisdom or the realization that I was a healthcare deadbeat that propelled my business into providing healthcare benefits for my employees. The very force that made me provide healthcare benefits back in 1981, is the exact same force that is the best solution to our healthcare crisis today. That force is the market place. The market place is the playing field for free enterprise. It produces quality, efficiency, and excellence. It is sparked by incentive and reward. It is doused by taxes, punishing regulation, and unfairness. Then it produces inefficiency and mediocrity.

I had some pretty good employees back in 1981. I hoped I was paying them well enough to keep them. I just wasn't sure. I tried to compare their salaries with those of other shops, but never felt comfortable with the accuracy of the comparisons. One thing I know for sure, many shops, with the exception of auto dealerships, did not provide healthcare benefits for their technicians.

It didn't take a genius to figure out that I could compete for employees better if I provided something only big business was providing. By competing for, and keeping better skilled and motivated employees, I was able to sell a better product. When I sold a better product, I attracted more customers. When I attracted more customers, I earned more money. When I earned more money, I spent more money, I saved more money, I invested more money, and yes I paid more taxes. That simply put is a free enterprise market place and how it operates. It is not more complicated than that.

My accountant at the time almost spoiled the fun of participating in this new benefits game. When it came time to do the end of the year tax returns, he pointed out to me that the portion of the healthcare premium I had paid for myself could not be deducted as an expense, and therefore would be added to my income. I was so angry I felt like canceling the whole benefit. In fact I was a lunatic, being unable to understand why I was being treated so unfairly. It just didn't make any sense. Of course I came to my senses and recognized the whole reason I started the benefit in the first place was for the employees. I would simply have to live with it. But I didn't like it.

I always ask myself, "what decision would I have made if I knew before hand that I would be unable to deduct my share of the premium?" I still do not know the answer to that question. Perhaps it may have delayed my decision to provide health benefits for my employees.

In 1986, Congress threw me a bone. They now allowed me to deduct 25 percent of my premium. I still can't figure the rationale. If it was unfair to tax me on 100 percent of my premium, why has it now become fair to tax me on 75 percent? It still does not make any sense! Why am I different from the person that works for me? Why am I different from the president of General Motors? I pay the same income taxes as they do. Perhaps more or less based on our incomes. Neither my employee, nor the president of General Motors have the amount of their healthcare premiums added into their incomes at the end of the year. Why do I? Let me ask that question again. Why do I?

The 25 percent deduction wasn't any great thing, but it was better than nothing. Like any begging dog, I took the bone and chewed on it. Unlike the majority of the senseless things that Congress sees fit to impose on small business, they had a built-in bone throwing stopper for this dog. Congress built right into the Tax Reform

Act of 1986 a sunset for the 25 percent deductibility of my healthcare premium. The deduction ended in 1989.

From 1989 until 1995, Congress debated extending the 25 percent deduction. Every year Congress made the same mistake. They didn't do the fair and sensible thing. They didn't do the one thing that will add incentive to small employers to seek healthcare benefits for them and their employees. Congress didn't make the deduction permanent, and they didn't make it a 100 percent deduction.

Instead, after annual debate and holding the dogs at bay, they always chose to spare another bone. Congress has extended the 25 percent deduction every year since 1989.

A few years ago, I hired a new accountant. Every year he calls and asks to retrieve the invoices from my healthcare carrier from the file, in order to calculate how much of the premium was paid for myself. Each year I dutifully retrieve them. I guess that makes me a Retriever. I reported the numbers knowing that only 25 percent of those numbers would actually be deducted as expenses. My bone. The remainder was added to my income. I would like some meat on my bone thank you.

In January of 1995, I came begging for my bone again. Congress had not extended the 25 percent deduction for 1994. Thankfully Congress threw another bone and extended the deduction through 1995 retroactive to 1994 and raised the deduction to 30 percent.

The Health Insurance Portability and Accountability Act of 1996, also known as the HIPAA bill, started to put a tiny bit of meat on the bone by raising the deduction to 40 percent in 1997, 45 percent in 1998, and eventually to 80 percent by the year 2006. Chairman Archer's Taxpayer Relief Act of 1997 continued adding meat by making the final deduction 100 percent by 2007. More meat.

What I have come here to ask for is for Congress to push through legislation that would allow for the 100 percent deduction sooner than in 2007.

I don't mean to sound greedy, in fact, I am grateful for the 100 percent deductibility of health insurance. But the problem is it doesn't go into effect until 2007. That's almost 10 years away.

Congress obviously recognized the unfairness and inequity of the deduction dilemma by passing the Taxpayer Relief Act of 1997. The question remains: Why is it necessary to make small businesses wait until 2007 to deduct 100 percent of their health insurance when corporations have been receiving this deduction for years. The formula to reach 100 percent is too slow and does not provide small employers enough incentive to obtain healthcare benefits for their companies.

At a time when most small businesses are finding it difficult to continue providing healthcare benefits for themselves and their employees, it is bad for the market place to not provide as much incentive as possible.

I ask you, in the spirit of fairness, and in the spirit of concern for healthcare reform, to please pass legislation that will speed up the phase in of the 100 percent deductibility of healthcare premiums. Members of the Oversight Subcommittee, I think this will be a great step, and a great signal that healthcare reform is still a priority in this Congress.

I apologize if there seems to be a facetious tone to my testimony. I mean no disrespect. I make the analogy of the dog and the bone only as a means of highlighting the silliness of this debate. This debate should be over and done with. I am frustrated, and my fellow small business owners are frustrated by the obvious and blatant unfairness of this tax policy. I think the time is right to act on the legislation I have requested here today. I wish you well in your efforts to achieve a more fair tax policy for all Americans, and thank you for the opportunity to testify.

Chairman JOHNSON. Thank you very much. Mr. Risalvato, in talking with other small business men, if they could deduct 100 percent of their premiums, if we made that possible immediately, would that be a sufficient motivation for them to offer a health insurance plan for their two or three employees?

Mr. RISALVATO. I believe in a large percentage of the cases, the answer to that would be yes, because many recognize that they need it. And they seem to be, by the way, the only ones that are aware that they can't deduct it. When I talk to other small business owners that are C corporations, they aren't even aware of the issue.

But the ones that are aware of the issue are the ones that have gone to do it, and I guess in the course of being sold the insurance through agents or brokers or even in consultations with their accountants. Once they learn that fact, it sort of puts the brakes on. It certainly slows up the process.

In answer to your question, I believe that a large percentage would, in fact, immediately negotiate for benefits for themselves and their families.

Chairman JOHNSON. That's a very interesting answer, and I think an important one. One of the things that's very difficult in this area—and I had a meeting with Joint Tax about this yesterday—is that a lot of the information we are using to estimate the impact of this bill comes from 10 years ago. Now in 6 months, there will be some better information available. But you know, 10-year-old data in health care and in the health insurance business is practically useless.

One of the issues that came up, and perhaps some of you can shed light on it, we believe—the Congressional Budget Office believes that 7 percent of the uninsured are in the 28-percent bracket. So they would get a significant deduction. One of the problems with deductibility is that someone in the 15-percent bracket doesn't get a very good incentive. So that's why the employer incentive is very important for small businesses.

That does lead to another issue that the two of you might want to comment on, and that is the access of very small employers to group plans, in your estimation, in our market. That's one question.

The other question is, if 7 percent are in the 28-percent bracket—and according to Joint Tax, if there's a 10-percent price cut, there's a 6-percent increase in participation with a 28-percent price impact, shouldn't there be a fairly significant impact at least among the 7 percent of the uninsured who are in that bracket.

I'd like your comments on that, because to this point, what we're mostly getting is estimates as to how this will be an equity bill. And it will be an equity bill. It will give people who are already buying their own insurance, and who get no ability to deduct at all, the right to deduct. If we're able to implement this in 1 year, it will be for everybody and that's actually the way it should be.

That still is a big price for equity, which is a fair price to pay. Equity is important. But if you talk about expansion, then you have to try to figure out who is going to be able to benefit from this.

Only if we develop the maximum incentives to participate in the current market structure, can we determine what the cost of subsidies for premiums would be, which is the next and final step and was part of the bipartisan national health care proposal that was introduced a number of years ago and came very close to passage, although the decision was made for the issue not to go to the floor.

In that bipartisan bill, and in the Bob Michel proposal that Mr. Gradison will remember, we did close that final access issue, that market access issue with subsidies on the basis of premium. But you can't get there yet, and I have been struck by how little we know about the uninsured and how little we know about how many of them are employers who actually have a viable enough business so that if they could deduct the premiums, they would do so for themselves and their two or three employees.

I'd like your thoughts on how powerful this lever could be if we do it right, and what you know about that 28-percent group.

Mr. GRADISON. Madam Chairman, we don't have any independent data. We rely heavily upon data that comes from your Committee and from the Congressional Budget Office and sources of that kind.

Clearly, the recommendation that you have put in the form of a bill won't solve the whole problem. But clearly, it is a step in the right direction and will help you not only gain experience, but be in a better position to estimate what additional steps are needed.

As we indicated in our testimony, ultimately, in addition to the question of deductions, the question of credits or vouchers or something—they are about the same thing, really—needs to be considered in order to reach those, who are very numerous, who pay little or no Federal tax, but because of the cost of health insurance are unable either to buy it on their own or to afford to share in the cost of the plans offered by their employers.

The most recent estimate is that there are 6 million Americans entitled to health insurance offered by their employers who do not take it up. And there are many reasons for that. But the main reason is affordability, because of their judgment that they are either unwilling or unable—more likely, unable—to meet the costs of the premiums, deductibles, and copays that would be involved.

Chairman JOHNSON. Just to interrupt you there on that point. The 6 million that are offered insurance by their employers and don't participate, are those employees offered plans in which the employer offers no subsidy at all?

Mr. GRADISON. I think they are generally plans where the employer does, but there certainly has been a tendency of employers, as costs have risen rapidly, in many instances to shift a growing portion of that cost of the premium to the employees, especially for dependents.

These data are spelled out in an article that appeared in Health Affairs in November of last year, and I think you might find that a useful source.

Chairman JOHNSON. And then, George, perhaps you might know, I was very surprised, in talking with the Joint Tax Committee, that they believed that there are many employers out there who offer health insurance to their employees with no premium subsidy.

Frankly, I've never run across that in my State. And I wonder if you are aware of plans of that sort, and if so, do you have any idea how much of the market is plans in which employers offer access to group insurance, but don't participate in any way in subsidizing premiums?

Mr. REIDER. I do not have those statistics, and I would be more than happy to gather with the staff anything we can provide, because I think that certainly is a point of interest, and highlighted by what we've said here today.

Chairman JOHNSON. Excuse me, I'm sorry. I thought we had a little more time left than we do. We only have 5 minutes to vote. I am going to have to ask you to suspend and we will be right back and start with your questions. Then we'll go to Mr. Coyne and Mr. Portman. Thank you.

[Recess.]

Chairman JOHNSON. Since we are going to have votes periodically, we'll try to get back promptly and reconvene.

Mr. Reider, I think what I asked you was to comment on a number of issues. First of all, what kind of incentive, in your experience, the 28-percent group would experience under the deductibility bill. And then what you know about this issue of the data in regard to the uninsured. And then, last, I know Connecticut has done a lot of work in trying to create more affordable group options in which a small business can participate. If we were, for instance, able to go to 100-percent deductibility for the self-employed, what kind of incentive do you think would encourage very small companies to participate in the group market, and is there an affordable group market in which they can participate?

Mr. REIDER. Yes, and the question is of tremendous importance, but I would not have the statistics nor the expertise to speak from a tax standpoint. But as I indicated, we will certainly have staff gain any information we can.

You raised the point of the fact that there were group policies that didn't offer any subsidization, and again, I don't know the specifics. But I do sense that there may be some movement, as was mentioned here just a few minutes ago, where that is happening for a variety of reasons. And I think it will be very difficult to determine that. But again, that's just a personal observation.

As far as Connecticut and this small group business, I referenced the fact that we had the Health Reinsurance Association and that mechanism was put in place back in, I think, 1975, which intended to help address the small business availability, affordability issue. And I think Connecticut has continued to be active in that, and in fact, when HIPAA was passed, much of that mechanism was put in place as the alternate for that arena.

Chairman JOHNSON. Do you mean under HIPAA the individuals were given access to that small group market?

Mr. REIDER. Yes. Well, they were given access to the Health Reinsurance Association, which allowed for availability, and then there is a limit on the amount that could be charged over and above the standard policy. That was available in the State of Connecticut, and that was the alternative mechanism that we turned to when we implemented the HIPAA measures. But we were pretty much there when that came down, and it has worked very, very well, I believe.

Chairman JOHNSON. Well, in terms of your experience of the insurance market, does a 28-percent incentive constitute much of an incentive to participate? And is there any way that individuals can get into an affordable market?

Mr. REIDER. Again, I find that of great interest. I would just hesitate to comment, Mrs. Johnson, because it's an area that I don't have the statistics and wouldn't have the expertise.

I would say this: As I indicated, we certainly applaud your efforts in looking at this and understanding it fully, because I think today in our country, affordability and availability remain a very critical matter.

Chairman JOHNSON. I'd like to ask both you and the HIAA to try to look at your sources of information and try to see how many—for instance, what portion of the small group market has no employer subsidy in it. How real is that?

And then whether there is any data that you have access to that might help us judge if we went to 100-percent deductibility for the self-employed, what groups that would bring, what small groups that would bring into the group market.

And then if you can find any data that would help us to determine who this 7 percent of the uninsured that are in the 28-percent bracket or above are, and what likelihood there is that deductibility would be a sufficient incentive for them to participate. Because those are all questions that we don't have answers to, and it's very hard to determine the impact of this legislation.

Then one last thing I'd like you to look at is 15-percent deductibility and 28-percent deductibility as an incentive, if we opened up the Medicaid managed care plans of the States to these people. So that you would definitely have a lower cost plan, a more affordable plan, and a modest incentive. If you could get back to us on those kinds of issues, I would appreciate it.

Mr. REIDER. Surely will. We will gain any information we can and provide it as quickly as we can.

Chairman JOHNSON. Thank you.

[The information is being retained in the Committee files.]

Chairman JOHNSON. Mr. Coyne.

Mr. COYNE. Thank you, Madam Chairman. Congressman Gradison and Mr. Reider, given that it's pretty much agreed by everyone that a significant number of low-income individuals are not going to be able to benefit from a tax deduction because they just have no tax liability, I was just wondering if either one of you have any suggestions about what we could do for those people who would be left out of any benefit from a tax deduction program.

Mr. REIDER. What I testified to here today—and there are many elements, but one of the things that may be helpful to some extent is the fact that currently under HIPAA the companies can choose to place the person with one of several policies. And we think the intent clearly was that if they were the most popular policy, they'd be the most attractive dollarwise and so on.

And what we believe, from the NAIC perspective, is it would be well to look at that and make it necessary that the companies spread that risk further, and therefore capture perhaps a lower rate than now is being offered, which is creating problems in some instances.

So again, as far as the tax portion of that, I cannot comment, but I can comment that I think this is one in a number of steps that might be helpful.

Mr. GRADISON. Mr. Coyne, I should think that once you reckon with how much you may have available in the form of funds for tax reduction, that you might want to look at some mix of deductions, credits, or vouchers. Use deductions and credits as a means to target these funds to where they would do the most good.

I can't quantify that. And we're going to try to help with the numbers that the Chair has asked for, but we keep coming back to the same sources that you have, so I don't want to leave the impression that these numbers are easy to come by.

Mr. COYNE. Mr. Reider, in your testimony, you said that health insurance prices under HIPAA are much more reasonable in States with high-risk pools. Does that mean that instead of encouraging people to buy expensive individual policies, we should create risk pools or allow them to buy into larger public plans?

Mr. REIDER. Again, and I repeat, I think what's important, we believe, is to address this specific issue where it would force a broadening of the risk and therefore, we think, a more attractive price than what we've seen in some instances, which is rather troublesome to all of us.

But we are not suggesting any specific action that would mandate it in each and every State, because the marketplace is different in each State. There are different companies, their employment picture, the availability, and whatever else.

But we do think, and I can speak now for the State of Connecticut, that our approach to this, because it has a long history and whatever, has worked very well. And one of the things that we do at the NAIC is to share information and success, or problems as well to avoid them.

And I think that all of the commissioners that I am aware of and the discussions I have had is that everybody is trying to work very hard on the same issue that you are working on in their given State, working with the legislatures, working with the authority they have to try to correct some of the problems, which is high price. And when you don't have affordability, you don't have availability, so they tie together directly. And I think there is a lot of activity by individual States.

So I would not suggest that mandate, you do this, because I think you could end up in more difficulty. But to simply suggest that this particular provision be corrected, and then allow the States to determine how they go about achieving that spread.

Mr. GRADISON. Mr. Coyne, our observation with regard to the HIPAA experience is that the problem of affordability is concentrated in those States which don't have risk pools and therefore, that the focus should be on trying to encourage them to do so if they can.

There is a lot to be said for risk pools in terms of improving the functioning of the very fragile individual market. For many years—Mr. Vaughan might remember, I don't remember for how many Congresses Mr. Stark and I would put in bills to encourage the creation of risk pools, but we didn't get much encouragement anywhere else and never were able to trade it with the Senate for anything so we stopped doing it. I mean, that's really what happened.

But I still think that there is a lot to be said for the State level. It doesn't have to involve Federal encouragement, necessarily, but I think there is a lot to be said for recognizing that the HIPAA affordability problem is concentrated in the States which don't have risk pools.

Mr. COYNE. Thank you both.

Chairman JOHNSON. Mr. Portman.

Mr. PORTMAN. Thank you, Madam Chairman. I appreciate the testimony from all the witnesses this afternoon. Bill Gradison spent 18 years on this side of the table and became really the preeminent expert on health care on this Committee, so it's a little intimidating to ask him questions. He knows a lot more than we do. But it is also a good opportunity to get some information.

I also would say Tim Miller is behind me, Mr. Gradison, who was serving you ably for many of those years. You trained him well.

I have a number of questions, but I think what I'd like to focus on is the long-term care ideas you have. I know in your testimony, in your written statement, you go into some detail as to some additional thoughts beyond the deduction that is in Nancy Johnson's bill.

In your oral statement, I think you were not able to get into all that, and I guess what I'd like to do is to hear a little more about long-term care from you. I think you would say that Nancy Johnson's proposal is a good start.

Mr. GRADISON. Yes.

Mr. PORTMAN. Providing deductibility for long-term care. And one question I just have, out of curiosity again given your background and expertise, is why other proposals haven't included more of a focus on long-term care. I think, Nancy, yours is the only proposal out there that has a deduction for long-term care that is across the board.

And then if you could address some of the other things we could do in terms of long-term care.

Mr. GRADISON. Well, Mr. Portman, first of all, it's a lot more intimidating to sit down here than it was from up there. [Laughter.]

But I think the reason is that such a major step was made 2 years ago in the tax clarification with regard to long-term care. I mean, that was a very major step sought by people who want to encourage the development of a private market.

It was sought by those who are concerned about the long-term cost to Medicaid of nursing home bills. It was sought in part by those who were trying to learn from the experience of States like Connecticut which had taken the lead in some important experiments with regard to the interaction of long-term care insurance to the spend down requirements.

So now, frankly, from our point of view, we are approaching the long-term care issue on two fronts. The first has to do with the issuance of the regulations, and the Treasury has been very cooperative and open to suggestions. It is remarkable how many 12-page, single-spaced letters we send to them on long-term care because of the number of issues that were left, as is often the case, unresolved by the passage of those statutes.

But now our attention has turned to the tax status of these policies at the Federal and at the State level. We have been very aggressive this year in encouraging the legislatures to consider providing the same treatment at the State level for long-term care that you provided 2 years ago.

So these additional steps are very encouraging, but they have implications beyond just long-term care. For example, the 7½-percent threshold, as a practical matter, almost eliminates the possibility of deductibility for most folks.

But I recognize that if you are going to reexamine the 7½-percent threshold, quite apart from the revenue cost, it's unlikely that you're just going to do it for one particular kind of health insurance. You probably would want to do it more broadly.

Mr. PORTMAN. Which would be quite costly.

Mr. GRADISON. Which would, of course, be far more costly.

Mr. PORTMAN. Let me ask another question, since we have you here with your experience on health care and the relationship between health care and other issues. One I just will mention is that very much on the congressional calendar right now is the notion of a patient's bill of rights, the PARCA bill and so on.

And you go into some detail in your written statement about the impact on affordability, and therefore, accessibility, along the lines of what Mr. Reider was talking about a moment ago. And I think we can't forget those issues. This is not all tax driven, after all, and a lot of it is driven by regulation and mandates and so on.

But the larger question I have is tax reform. And if you could just for a moment step back and give us some sense of how tax reform as it's talked about—let's say the flat tax, for instance, where there would be a so-called pure flat tax, which has implications on the corporate side as well as the individual side on health care.

How would that impact health care, and do you see any kind of major simplification effort out there that would be compatible with the kind of a health care program that you are talking about?

As an example, in your long-term care proposals, you have a number of deductions and credits and so on. Those would seem inconsistent with simplification. Could you just address that generally.

Mr. GRADISON. We're very concerned about this, Mr. Portman. There's no question that these tax provisions as we have them today are having a positive effect in encouraging greater coverage, particularly at the group level, under health insurance. And you are going to hear some testimony relevant to this in the next panel.

But if the employer deductibility were eliminated or it were retained, but the exclusion at the individual level were eliminated, there are solid reasons for concern that the number of people who would actually purchase health insurance would drop very, very dramatically.

Nobody can promise you those amounts, but I think it's something that requires great care. There are definite tradeoffs involved in trying to broaden the base. In many respects, I look at what happened back in 1986, which was a major step in that direction, and then what's happened since then. And I have a feeling that while what we did was well-intentioned, that there's been a drawing back, a sense that you have to have more targeted changes, that just leaving this up to the individuals and families and businesses to decide isn't enough to meet national objectives.

And certainly, a lot of what was done in 1986 has been, if not totally reversed, at least the direction is going back to the way it was before 1986.

Mr. PORTMAN. Thank you. I look forward to further dialog on this and other issues. Thank you, Madam Chair.

Chairman JOHNSON. Thank you.

Congresswoman Thurman.

Mrs. THURMAN. Thank you, Madam Chairman.

I really want to start with something that came to my attention from a letter that I received in my office about somebody who was working who could not afford health care. And this is the excerpt from the letter, and then maybe we can have some questions on this.

Mrs. Thurman, you may remember that a little over 2 years ago I called your office and asked for help for a friend of mine. She had just been told by her doctor that her pap smear had come back positive and that he recommended surgery. At that time, she was employed as a bartender at a local restaurant and was not able to afford medical insurance. If affordable medical insurance had been available, she would be alive today.

Marti died of one of the most easily discovered and easily curable forms of cancer today, cervical cancer. It was discovered in time. Had adequate and affordable medical insurance been available, she would have had a hysterectomy immediately and that would have been it. I am not looking for someone to blame. The blame is shared by all of us.

Mr. Risalvato, let me ask you this question as a businessowner. If that 100 percent, based on the fact of the statistics that we're hearing today, that in fact, employers want more participation by employees and that, in fact, in some cases they are not providing at all, would that 100-percent tax deductible have helped, do you think, Marti, in this case?

Mr. RISALVATO. There's no way that I could tell you what it would have done in that instance. I can tell you that when I learned I couldn't deduct my own, I had already made the decision, and I still wonder how I would have made the decision.

I still provide health care benefits for my employees. I have still to this day never taken a penny from them. That is a heartbreaking story, and not to seem without compassion, but shouldn't some onus be put on the individual to have purchased health care insurance, or put an importance on it on their own?

And I just think that if the costs were lower, there would be more likelihood that the employer would have provided it. If there was a deductibility, there would be more likelihood that the employer would have provided it. And in this instance, there would have been more likelihood that the individual would have taken their own personal responsibility to do it for themselves, had not the employer done it.

The key here is cost. The Chairman, in her opening statement, mentioned something that I don't always hear from people that are educated in health care. And that is the fact that there was a time when an employer provided for their employee a benefit rather than a pay increase or something else. You noted that in your opening remark.

And that is what motivated me when I provided the health care benefits. I was a much younger man at the time. I was in good health, and I wasn't thinking of myself. I was thinking of the employee. And I do believe that many employers feel exactly as I do. This notion that small employers or large employers, for that matter, would just prefer to pocket the money rather than be concerned about the employee, I think is absolutely false.

I have a genuine concern for my employees. I find that most of my small business colleagues have the same genuine concern. Would that 100-percent deductibility have helped Marti? There's no way I can answer that. I can tell you that that is one step——

Mrs. THURMAN. Well, let me ask you this.

Mr. RISALVATO. Yes.

Mrs. THURMAN. Would it have put you in a situation—and I don't know what's your situation, but you said in your testimony that you've talked to other employers because you've been involved in this issue.

Mr. RISALVATO. Yes.

Mrs. THURMAN. If this was a skilled worker that was making, maybe not minimum wage, but more than minimum wage but still at a very low rate compared to trying to raise a family. If they had had that 100 percent, would they give more benefits? Would that want them to come into an employee benefit package for them? Would they look at a 50–50 split? Would they be looking at a 75–25 split?

Have they talked about that much in what they would be offering their employees as a 100-percent deductibility?

Mr. RISALVATO. Yes, I have spoken to many, and it ranges from, I could pay a little bit but I can't afford the whole thing, to I'd like to make it an incentive package where I can pay for as much of it as possible to take some of the burden from them.

Keep in mind, an employee that has these benefits does not have that worry and he's a better employee, and that's what we're trying to make.

Mrs. THURMAN. Do I hear the issue—I mean, I've talked to some businesses that say, well, I can't afford this because it will make me less competitive. And I could tell you my response would be it would probably make you more competitive. But even in 1994 when we were talking about it and trying to get more businesses to come in, they were saying, Oh, no, you can't do this to us, this is going to hurt our bottom line, we won't stay competitive in the marketplace. There were all these excuses to why we couldn't have this happen.

But yet this is a perfect example of what happens to folks who don't have access to medical care. And I don't disagree with the personal responsibility. But my guess is probably as a bartender, at least in that area, if they were making $12,000, $15,000 a year, I'd have been surprised.

Mr. RISALVATO. Please, Mrs. Thurman, don't categorize these as excuses when I am trying to pay the mortgage and the electric——

Mrs. THURMAN. I understand.

Mr. RISALVATO [continuing]. And keep the doors open to keep jobs. And I can tell you from personal experience, I stand there today right now. I am in business for 20 years. My business every day is a struggle to keep the doors open. I provide health care benefits as a small business owner for my employees.

When we start talking about some of these mandates, and please take this back to your other colleagues in Congress, don't tinker with this system by making mandates, because you make it worse. You put people like myself in jeopardy of continuing a business, let alone continuing providing for the ones that I already am providing for.

If tomorrow I need to make a decision as to whether I pay the electric because they send a notice that says if it's not paid on such and such a date you have no electricity. If I have no electricity, I don't have gas pumps, I don't have power to run the lifts and everything. If I am faced with that decision or paying a health care premium, you tell me which one should I make tomorrow.

So we are in the exact same boat. When we ask for the 100-percent deductibility, we are asking for one tiny little step that may be a motivation or a help to make us provide it, thereby putting more people in the system and eliminating a little bit of cost shifting. That's what we're asking for.

But that's only one thing. There are many other things. The bottom line is the cost of the premium. It is no longer the situation where I'll provide the benefit because I can give the employee something of great value, rather than cash, pay increase. It is no longer that. It has gone from that to where I cannot afford it at all.

And we've done some tinkering. We've done some good. We've got people tugging at a pendulum. And the object is to keep that pendulum right in the middle. I mean, we went through some serious changes in the last few years that pulled the pendulum way back, and now I think maybe the pendulum is starting to come back again this way. And it is going to keep doing that. And it's up to the Members of Congress to help direct it so that pendulum stays somewhere in the middle.

But to put into this argument that small business owners want to keep the cash rather than provide the benefit is false. And that's not to say that there won't be any situations like that. Of course there will. There will be those small business owners or big business owners who are going to say, why should I provide that? I'm going to make a little extra profit for myself.

By and large, a small business owner needs peace of mind as well, and he gets that when his employees are happy and when his employees can do the job and they can do it without him being there. Health care benefits is a means of providing that peace of mind for the small business owner as well.

Help us with a little incentive. That's what I am asking.

Mrs. THURMAN. We should thank you from this Subcommittee to let you know that we do appreciate that commitment that you've given to your employees. That is an extremely important thing, and I hope that message is to show that competitiveness and the marketplace is not jeopardized because you happen to give a better package to your employees.

Mr. RISALVATO. Thank you.

Chairman JOHNSON. In closing, let me ask particularly Mr. Reider or Mr. Gradison. You know, one of the options under HIPAA was for States to allow individuals—because the most difficult part of the bill was individual portability—individuals to join the State employees benefit plan or some of the largest groups in the market, because while risk pools are important, they are 150 percent of premium. COBRA is important; it is 102 percent of premium.

Frankly, most people are uninsured because they can't afford that kind of premium. And one of our goals in HIPAA was to really encourage continuity of coverage between jobs by giving you an affordable option. COBRA is really not affordable, and neither are the risk pools.

It's better than the States in which there was 400 and 500-percent increase in premiums. But this is very relevant for the small employers. If we give them deductibility, but all they can join because they are self-employed is a program whose average premium is 150 percent of the group plan, they can't do it.

Are the States making any progress toward opening up more affordable group type plans or group levels of cost plans to individuals by either incorporating them in larger plans, which was what HIPAA's vision was, as one option, or incorporating them into publicly structured HMOs like the Medicaid Programs?

Mr. REIDER. Again, I can't speak with certainty as to what each of the States has done. Again, that's the type of question that we'll be more than happy to go back and explore and try to see if anybody has taken an innovative approach in that regard.

Again, just speaking for Connecticut one more time, we think we've done some things that have been very helpful—and I say we in the sense that it goes back long into history but I think we all have to continue to search for ways to get to where you want to be.

Chairman JOHNSON. To my knowledge, Connecticut hasn't solved the problem of creating access to a more affordable plan for individuals either.

Mr. REIDER. Right.

Mrs. THURMAN. One of my goals in sponsoring the children's health proposal is that I hope in States like Connecticut that rather recently went to a Medicaid managed care structure and now with the children's health, that we'll develop a structure through which it will be possible to see how much would it cost to help people into that structure.

But I think this is a critical piece to sort of build down from the top, affordability, so we minimize the population that is going to need a premium subsidy.

Mr. REIDER. I want to just quickly comment, and you are very much aware of that issue, and part of that is the HUSKY plan which attempts to make insurance available to the young people in the State. I think that has been a very positive step.

But we will explore and look for anything that might be helpful in the spirit of what you spoke of.

Chairman JOHNSON. Thank you. That would be very helpful.

Mr. GRADISON. Mrs. Johnson, with regard to HIPAA, as you said earlier, the group to individual part is the part that has problems. That problem is focused on the less healthy of those who are entitled to the group to individual option and the guaranteed issue to that group. The healthier ones can go into the individual market today.

Chairman JOHNSON. But are the premiums a lot more than the group premiums? Even for healthy individuals?

Mr. GRADISON. I would like to submit for the record some examples of what the premiums look like.

Chairman JOHNSON. That would be helpful.

[The following was subsequently received:]

1997 Monthly Health Insurance Premium Quotes for Selected States*

State	Family of 4, $1000 Deductible	Single, Age 40–44				Single, Age 45–49			
		$1000		$2000		$1000		$2000	
		Male	Fem	Male	Fem	Male	Fem	Male	Fem
Texas	$181	$80	$104	$58	$76	$100	$121	$73	$90
Georgia	$200	$78	$101	$60	$78	$98	$119	$76	$92
Virginia	$194	$77	$100	$57	$74	$96	$117	$72	$88
Illinois	$239	$95	$124	$72	$94	$119	$144	$91	$111

Monthly Premiums

*Insurer: A large multi-line national health insurance carrier. Product: PPO plan with $1000 or $2000 deductible as indicated. Family: A two parent family of 4: parents age 35–39. Geographic Location: A relatively high cost (urban) area, for each state.

Mr. GRADISON. I think you will find the policies vary enormously from a lot of the group policies. They generally have higher deductibles and higher copays, so they are not precisely comparable policy to policy.

But the big problem with HIPAA are the higher cost, sicker individuals who don't automatically easily qualify for individual coverage. Now what that says is that they have to be subsidized. If they are put into a pool with the State employees or if they're put into a Medicaid managed care pool, they still have to be subsidized.

And the question, in my view, is whether that subsidy should be hidden or whether it should be transparent. The same issue has arisen from time to time when suggestions have come up at the Federal level about adding certain groups and making them eligible for the Federal Employees Health Benefit Plan.

If they stand as a separate group, you still have the question of how to pay for them. If you don't, then it increases the cost for other Federal employees.

Chairman JOHNSON. I agree that if you segregate them off as a separate group. But I think some of us working on HIPAA envisioned a State making a decision that anyone who qualified under HIPAA would automatically go into, for instance, the State employee benefit plan, so you'd get the healthy as well as the sick.

You would get in that big plan the risk spreading that you would need because you'd get everybody, because the inducement in HIPAA was to keep your coverage constant. I mean, have no break in coverage so you would never be eligible for discrimination on the basis of preexisting conditions. So we say to you, we are going to protect you from discrimination on the basis of preexisting conditions if you will make the investment to keep your insurance going between jobs?

And if a State, any State, had put them all into the State employee system, then healthy people as well as sick people would have gone into the system. When they went to the next job, well people and sick people would go on to the next job.

I think I did not appreciate how likely it was that States would then individually underwrite them. And that is true. In that system, the sick people can't afford insurance and the well people can.

Mr. GRADISON. But with regard to the well ones—and it's not a perfect term—but by well, I mean the ones who could qualify without any preexisting condition limitation in the individual market; if we pursue what you are outlining, they would effectively be told that this is the only option available to you if you go from group to individual.

Now some people might prefer to maintain their coverage by going into the existing individual market, buying a high-deductible policy. I would say they quite likely in many cases would find it less expensive than going into the State pool.

So you can't automatically, in my opinion, assume that you are going to get everybody, all the group to individuals, unless that is the only option available to them. And that, in effect, would be taking away from them an option that they have in the market today as an individual, which is to shop for something that fits their circumstances which might be more or less expensive than a big pool.

I would like—I beg your pardon.

Chairman JOHNSON. Some examples would be very helpful.

Mr. GRADISON. We'd be happy to submit those.

[The following was subsequently received:]

HEALTH INSURANCE ASSOCIATION OF AMERICA
November 23, 1998

The Honorable Nancy Johnson
Chairman, Ways and Means Oversight Subcommittee
United States House of Representatives
1136 Longworth House Office Building
Washington, D.C. 20515

Dear Madame Chair Johnson:

On April 23, 1998 I testified before the Subcommittee regarding market-based initiatives to expand access to health coverage. Several questions emanated from that hearing, and your staff called recently seeking additional information.

During the hearing, you envisioned an arrangement where states could provide *affordable* health insurance coverage to individuals exercising their group-to-individual portability rights under HIPAA. Under the arrangement, "HIPAA eligibles" in a state would enroll in a large group such as the state employees' health benefits program, and HIPAA eligibles would be pooled and rated together with others in the group.

I observed in response that there could be complications with this arrangement. The following quote was my statement at the hearing

"On one hand, if a state required all HIPAA eligibles to enroll in the state program, these individuals would be precluded from purchasing coverage in the individual market, which they might find preferable. Specifically, HIPAA eligibles that could pass underwriting requirements of individual market carriers might prefer purchasing a type of coverage (e.g. high deductible) that isn't offered in the state program.

On the other hand, if a state allowed HIPAA eligibles to enroll in the state program, but did not require it, the HIPAA eligibles actually enrolling in the state program would probably be higher risk, on average, (if some lower risk eligible individuals chose to purchase coverage in the individual market). This could cause rates in the larger group to go up."

In response to your inquiry regarding an example, Kentucky serves as a case in point.

Several years ago, the State of Kentucky adopted a policy of allowing individuals who were refused coverage in the individual market to enroll in Kentucky Care—the state employee health benefit program. By last year, some 4,000 non-state employees had entered the plan. Last year, the Kentucky Department of Insurance reported that the fund was losing millions of dollars a month, and was rapidly spending down reserves. At the Department of Insurance's recommendation, the legislature closed Kentucky Care to non-state employees. This summer, the state was forced to take stronger measures, by closing the self-insured option, and severely limiting the plan choices available to state employees to mostly HMO coverage.

It is unclear how much of the adverse financial experience was due to the enrollment of non-state employees, versus other factors, but this clearly was an important contributing factor.

I hope my response is helpful.

Sincerely,

BILL GRADISON
President

Mr. GRADISON. I just want to take a moment to compliment all of you for your focus on this. I think there is an exceptional opportunity this year, especially if revenues become available as a result of the discussions on the tobacco issue, to plow that back into the health care field, along the lines that you and others up here on the Hill are discussing. I could envision that as being a very powerful health-related package for the benefit of the public.

Chairman JOHNSON. Thank you. And I thank the panel for your participation. You've been very helpful.

Now I would like to call up the second panel. Wayne Nelson, president of Communicating for Agriculture; James Klein, Association of Private Pension and Welfare Plans; and Paul Fronstin, senior research associate and director of the Health Security and Quality Research Program, Employee Benefit Research Institute.

Good afternoon, and thank you very much. If we may, I am going to start with Mr. Fronstin of the Employee Benefit Research Institute first.

STATEMENT OF PAUL FRONSTIN, PH.D., SENIOR RESEARCH ASSOCIATE AND DIRECTOR, HEALTH SECURITY AND QUALITY PROGRAM, EMPLOYEE BENEFIT RESEARCH INSTITUTE

Mr. FRONSTIN. Thank you. Madam Chair and Members of the Subcommittee, I am pleased to appear before you this afternoon to discuss continuation of health insurance coverage under COBRA.

My name is Paul Fronstin. I am a senior research associate at the Employee Benefit Research Institute, a private, nonprofit, nonpartisan public policy research organization based in Washington, DC.

EBRI has been committed since its founding in 1978 to the accurate statistical analysis of economic security issues. Through our research——

Chairman JOHNSON. Excuse me, Mr. Fronstin. Could you pull the microphone just a little closer. Thank you.

Mr. FRONSTIN. Sure. Through our research, we strive to contribute to the formulation of effective and responsible health and retirement policies. Consistent with our mission, we do not lobby or advocate specific policy solutions.

The goal of COBRA was to relieve the hardship employees and their families experienced resulting from the temporary loss of group health insurance by providing a period of transition to other coverage.

COBRA, as amended in legislation subsequent to its passage in 1985, requires employers with health insurance plans to offer continued access to group health insurance to qualified beneficiaries if they lose coverage as a result of a qualifying event.

COBRA coverage can be considered advantageous for most workers as it allows continuation of the policy one had in place at work. Although an employee can be required to pay 102 percent of the premium for COBRA coverage, workers can usually realize significant savings compared with purchasing an equivalent health insurance policy in the private market.

COBRA premiums will usually be lower than insurance plans purchased directly from an insurance company due to economies of scale in administrating group health insurance and the reduced risk of adverse selection.

Furthermore, employment-based health insurance typically covers a larger array of benefits than individually purchased health insurance for an equivalent premium. As a result, COBRA coverage would be a better buy than a plan purchased in the individual market.

COBRA coverage can be considered even more beneficial to older workers who would get a community rate. COBRA is also seen as advantageous in general because it improves health insurance portability and reduces job lock.

Many employers consider COBRA to be a costly mandate. Premiums collected from COBRA beneficiaries typically do not cover the costs of the health care services rendered because of adverse selection. The Clinton administration has recognized this in its Medicare buying proposal. In addition, COBRA recognizes it, as it allows employers to charge 150 percent of the premium for the disabled in months 19 through 29.

COBRA imposes an additional administrative cost on employers. Not only do employers have to administer the plan, they must also find and notify COBRA-eligible individuals. This process could be costly, especially for divorced and separated spouses and other dependents. While health plans are allowed to charge 102 percent of the cost of the health plan, the additional 2 percent may not fully cover these administrative costs. Many employers also view the penalties for noncompliance as excessively large.

Assuming that individuals electing COBRA coverage are a relatively higher risk population than the general work force, any expansion in the current law that affects either the size of the firm covered under COBRA or the length of time that former workers are eligible for continuous coverage would almost certainly increase employer costs for health insurance.

In addition, subsidies for COBRA coverage would increase the percentage of eligible workers electing COBRA coverage. While this might reduce the degree of adverse selection, it would still drive up the overall claim costs for employers.

One alternative to mitigate higher health care costs would be to allow workers to choose from plans that are similar to the current plan, such as plans with a high deductible.

It should be noted, however, that previous research indicates that access to continuation of coverage is not likely to have a major effect on the level of the uninsured, although there is evidence that the availability of continuation of coverage increases duration of unemployment, suggesting that it allows individuals to spend more time in productive job searches.

Another alternative would be to guarantee access to health insurance coverage either in the individual market or through State-sponsored high-risk insurance pools. HIPAA included provisions for group-to-individual portability for workers who have exhausted COBRA coverage. Under this provision, workers have an incentive to continue COBRA coverage in order to qualify for coverage in the individual market. As I already mentioned, this is costly to employers and workers.

In order to reduce costs to employers, COBRA could be repealed if group-to-individual portability were guaranteed at the time that a worker leaves an employer. This, however, would have the effect of shifting the cost of continuation of coverage mandates from employers to insurance companies in the individual market and ultimately to individuals covered in this market.

Thus, any expansion in continuation of coverage mandates either through COBRA or through increased access to insurance in the individual market would increase costs to workers, employers or insurers.

I would like to mention that HIPAA does improve portability as it makes it easier for individuals to get new health insurance on job change. But in contrast, COBRA guarantees portability as it allows workers to maintain their current health insurance plan.

If cost issues are not addressed with future COBRA expansions, employers may consider various alternatives to reduce, shift, or eliminate the impact of this increased cost. One alternative is for employers to continue requiring active employees to share in the increased cost through higher employee contributions.

A second alternative is to reduce or eliminate health care benefits for active employees and/or future retirees and their families. A third alternative is to reduce the size of the work force eligible for health insurance benefits.

Madam Chair, this concludes my statement. Thank you for the opportunity to testify this afternoon. I would be glad to answer any questions that you or Members of the Subcommittee might have.

[The prepared statement and attachments follow:]

Statement of Paul Fronstin, Ph.D., Senior Research Associate and Director, Health Security and Quality Program, Employee Benefit Research Institute

PRINCIPAL POINTS

• The goal of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) was to relieve the hardships employees and their families experienced resulting from the temporary loss of group health insurance by providing a period of transition to other coverage. COBRA, as amended in legislation subsequent to its passage in 1985, requires employers with health insurance plans to offer continued access to group health insurance to qualified beneficiaries if they lose coverage as a result of a qualifying event.

• COBRA coverage can be considered advantageous for most workers, as it allows continuation of the policy one had in place at work. Although an employee can be required to pay 102 percent of the premium for COBRA coverage, workers can usually realize significant savings compared with purchasing the equivalent health insurance policy in the private market. COBRA premiums will usually be lower than insurance plans purchased directly from an insurance company due to economies of scale in administering group health insurance and the reduced risk of adverse selection. Furthermore, employment-based health insurance typically covers a larger array of benefits than individually purchased health insurance for an equivalent premium. As a result, COBRA coverage would be a "better buy" than a plan purchased in the individual market. COBRA coverage can be considered even more beneficial to older workers who would get a community rate. COBRA is also seen as advantageous, in general, because it improves health insurance portability and reduces job-lock.

- Many employers consider COBRA to be a costly mandate for three reasons. First, premiums collected from COBRA beneficiaries typically do not cover the costs of the health care services rendered because of adverse selection. The Clinton administration has recognized this in its FY 1999 budget proposal. Second, COBRA imposes an additional administrative cost on employers. Not only do employers have to administer the plan, they must also find and notify COBRA eligible individuals. This process could be costly, especially for divorced and separated spouses and other dependents. While health plans are allowed to charge 102 percent of the cost of the health plan, the additional 2 percent may not fully cover these administrative costs. Third, many employers view the penalties for noncompliance as excessively large.
- Assuming that individuals electing COBRA coverage are a relatively higher risk population than the general work force, any expansion in the current law that affects either the size of the firm covered under COBRA or the length of time that former workers are eligible for continuous coverage would almost certainly increase employer costs for health insurance. In addition, subsidies for COBRA coverage would increase the percentage of eligible workers electing COBRA coverage. While this might reduce the degree of adverse selection, it would still drive up the overall claim costs for employers. One alternative to mitigate higher health care costs would be to allow workers to choose from plans that are similar to the current plan, such as plans with a high deductible. It should be noted, however, that previous research indicates that access to continuation of coverage is not likely to have a major effect on the level of the uninsured, although there is evidence that the availability of continuation of coverage increases the duration of unemployment, suggesting that it allows individuals to spend more time in "productive" job searches. Some of this effect may be due to state-mandated continuation-of-coverage laws and the existence of dual labor markets.
- Another alternative would be to guarantee access to health insurance coverage either in the individual market or through state-sponsored high-risk insurance pools. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) included provisions for group-to-individual portability for workers who have exhausted COBRA coverage. Under this provision, workers have an incentive to continue COBRA coverage in order to qualify for coverage in the individual market. As mentioned above, this is costly to employers and workers. In order to reduce costs to employers, COBRA could be repealed if group-to-individual portability were guaranteed at the time that a worker leaves an employer. This, however, would have the effect of "shifting" the cost of continuation-of-coverage mandates from employers to insurance companies in the individual market, and ultimately, to individuals covered in this market. Thus, any expansion in continuation-of-coverage mandates either through COBRA or through increased access to insurance in the individual market would increase costs to workers, employers, or insurers.
- HIPAA "improves" portability as it makes it easier for individuals with preexisting conditions to get new health insurance on job change. In contrast, COBRA "guarantees" portability, as it allows workers to maintain their current health insurance plan.
- If cost issues are not addressed with future COBRA expansions, employers may consider various alternatives to reduce, shift, or eliminate the impact of this increased cost. One alternative is for employers to continue requiring active employees to share in the increased costs through higher employee contributions. A second alternative is to reduce or eliminate health care benefits for active employees and/or future retirees and their families. A third alternative is to reduce the size of the work force eligible for health insurance benefits.

Introduction

Madam Chair and members of the committee, I am pleased to appear before you this afternoon to discuss continuation of health insurance coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). My name is Paul Fronstin. I am a research associate at the Employee Benefit Research Institute (EBRI), a private, nonprofit, nonpartisan, public policy research organization based in Washington, DC. EBRI has been committed, since its founding in 1978, to the accurate statistical analysis of economic security issues. Through our research we strive to contribute to the formulation of effective and responsible health and retirement policies. Consistent with our mission, we do not lobby or advocate specific policy solutions. I would ask that my full statement be placed in the record.

COBRA

COBRA's goal was to relieve the hardships employees and their families experienced resulting from the temporary loss of group health insurance by providing a period of transition to other coverage.[1] COBRA, as amended in legislation subsequent to its passage in 1985, requires employers with health insurance plans to offer continued access to group health insurance to qualified beneficiaries if they lose coverage as a result of a qualifying event. COBRA requires continued access for 18 months for covered employees, spouses, and dependent children who lose coverage when a covered employee terminates employment (for reasons other than gross misconduct) or there is a reduction in his or her hours of employment. COBRA requires continued access for 29 months for qualified beneficiaries who are disabled at the time of the qualifying event, or who become disabled within the first 60 days of the qualifying event, as clarified in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA also clarified that the 11-month extension for the disabled applies to all qualified beneficiaries, not just to the policyholder. COBRA requires continued access for 36 months for spouses and dependent children who lose coverage as a result of a covered employee's death, divorce, or legal separation. In addition, spouses and dependent children qualify for continued access for 36 months if a covered employee becomes eligible for the Medicare program.

Prior to the enactment of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), coverage could be terminated prior to the end of the maximum period if the qualified beneficiary became covered under another group health plan. However, OBRA '89 provides that COBRA need not terminate before the maximum period if the qualified beneficiary becomes covered under another group health plan that excludes or limits a preexisting condition.[2]

HIPAA includes additional COBRA clarifications affecting beneficiaries, newborns, and adopted children. First, newborns and adopted children will be allowed to enroll immediately under a qualified beneficiary's COBRA coverage, without being required to wait until the next open enrollment period. Second, COBRA coverage may be terminated as soon as any preexisting condition limitation in the new plan has been satisfied.

The coverage offered must be identical to that available prior to the change in the workers' employment status. The qualifying employee or dependent may be required to pay up to 102 percent of the premium (disabled qualified beneficiaries may be required to pay up to 150 percent of the premium for months 19 through 29). Group health plans for public and private employers with fewer than 20 employees are excluded from these provisions, as are plans offered by churches (as defined in sec. 414(e) of the Internal Revenue Code); the District of Columbia; or any territory, possession, or agency of the United States.

Advantages of COBRA

COBRA coverage can be considered advantageous for most workers, as it allows continuation of the policy one had in place at work. Although an employee can be required to pay 102 percent of the premium for COBRA coverage, workers can usually realize significant savings compared with purchasing the equivalent health insurance policy in the private market. COBRA premiums will usually be lower than insurance plans purchased directly from an insurance company due to economies of scale in administering group health insurance and the reduced risk of adverse selection.[3] Furthermore, employment-based health insurance typically covers a larger array of benefits than individually purchased health insurance for an equivalent premium. As a result, COBRA coverage would be a "better buy" than a plan purchased in the individual market.

COBRA coverage can be considered even more beneficial to older workers. Consider the following example for a small firm with a traditional fee-for-service health plan offered by Blue Cross Blue Shield in the Washington, DC, region for plan years starting March 1, 1995. Under the health plan, the annual premium for all workers with a family plan was $10,859. However, the expected cost of the plan varies greatly across workers. The actuarial cost for family coverage for workers under age 30 was $4,524, while the actuarial cost for workers ages 55 and older was $12,759. If a worker chooses COBRA coverage, the premium would be $11,076, or 102 percent of the annual premium. Young workers would have an incentive to forgo COBRA coverage, while older workers would have an incentive to accept COBRA coverage. As a result, the COBRA coverage pool of insured workers is adversely selected.

COBRA is also seen as improving health insurance portability and reducing job-lock. Concern about portability of health insurance arises in situations where a worker is leaving, or would like to leave, a job, and during periods of unemployment and labor force withdrawal. Concerns arise when a worker is unemployed or retires prior to Medicare eligibility and desires "bridge" coverage. In addition, portability could help alleviate the loss of insurance benefits when a worker is offered a new job that could alter his or her insurance status. Workers may remain with current employers for a number of reasons. A prospective employer may not offer health insurance. A waiting period may be required before a worker becomes eligible for coverage. The benefits package offered through the prospective employer may be less generous. And, the worker (or a dependent) may have a preexisting condition that would not be covered under the plan. These scenarios may result in "job-lock," or in employees forgoing job opportunities that could potentially increase their productivity and income. In other words, workers may forgo job opportunities in which a better match between the worker and the employer would enable the worker to perform his or her job more effectively. For employers that want employees to leave or retire and for employees who would prefer to change jobs, job-lock can be undesirable.

Disadvantages of COBRA

Many employers consider COBRA to be a costly mandate for three reasons. First, because of adverse selection, premiums collected from COBRA beneficiaries typically do not cover the costs of the health care services rendered. Second, COBRA imposes an additional administrative cost on employers. Not only do employers have to administer the plan, they must also find and notify COBRA eligible individuals. This process could be costly, especially for divorced and separated spouses and other dependents. While health plans are allowed to charge 102 percent of the cost of the health plan, the additional 2 percent may not fully cover these administrative costs. Third, many employers view the penalties for noncompliance as excessively large.[4]

COBRA Expansion and Alternatives to Expansion

Assuming that individuals electing COBRA coverage are a relatively higher risk population than the general work force, any expansion in the current law that affects either the size of the firm covered under COBRA or the length of time that former workers are eligible for continuous coverage would almost certainly increase employer costs for health insurance. In addition, subsidies for COBRA coverage, as previously proposed by the Clinton administration, would increase the percentage of eligible workers electing COBRA coverage. While this might reduce the degree of adverse selection if individuals previously at the margin because of low expected health care costs accepted COBRA coverage, it would still drive up the overall claim costs for employers, especially self-insured employers. One alternative to mitigate higher health care costs would be to allow workers to choose from plans that are similar to the current plan, such as plans with a high deductible. It should be noted, however, that previous research indicates that access to continuation of coverage is not likely to have a major effect on the level of the uninsured.[5] However, there is evidence that the availability of continuation of coverage increases the duration of unemployment, suggesting that it allows individuals to spend more time in "productive" job searches.[6] Some of this effect may be due to state-mandated continuation-of-coverage laws and the existence of dual labor markets.[7]

Another alternative would be to guarantee access to health insurance coverage either in the individual market or through state-sponsored high-risk insurance pools. HIPAA included provisions for group-to-individual portability for workers who have exhausted COBRA coverage. Under this provision, workers have an incentive to continue COBRA coverage in order to qualify for coverage in the individual market. As mentioned above, this is costly to employers and workers. In order to reduce costs to employers and workers, COBRA could be repealed if group-to-individual portability were guaranteed at the time that a worker leaves an employer. This, however, would have the effect of "shifting" the cost of continuation-of-coverage mandates from employers and workers to insurance companies in the individual market, and ultimately, to individuals covered in this market. Thus, any expansion in continuation-of-coverage mandates either through COBRA or through increased access to insurance in the individual market would increase costs to workers, employers, or insurers.

HIPAA also includes a provision to encourage states to provide medical coverage for high-risk individuals by granting tax-exempt status to organizations that establish high-risk insurance pools. These pools would be open to individuals with preexisting conditions. If individuals were to enroll in these pools instead of taking COBRA coverage, the burden of adverse selection would no longer fall on employers.

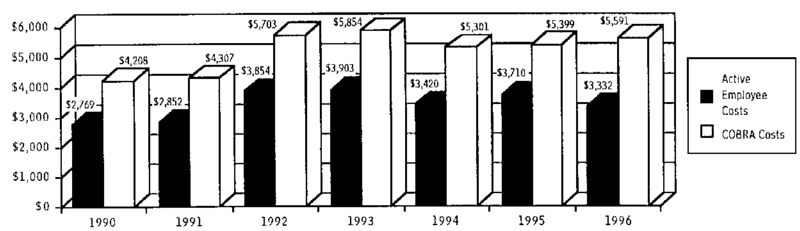
It should be noted, however, that state sponsored high-risk pools have not been effective in covering a significant portion of the population, in large part due to high premiums. Hence, any attempt to use these pools for health insurance portability may yield mixed results.

COBRA Costs and Beneficiaries

Several surveys have been conducted regarding issues surrounding the use of COBRA. A survey of approximately 200 firms, covering 1.42 million workers, conducted by Charles D. Spencer & Associates, Inc., in the spring of each year has typically yielded consistent answers about the problem of adverse selection and COBRA coverage. According to the survey, average employer claims costs for COBRA beneficiaries were $5,591, compared with $3,332 for active employees in surveyed plans in 1996. Thus, average continuation-of-coverage costs were 156 percent of the active employee claims costs. Large differences between active employee costs and COBRA costs have been typical since 1990, when average active employee costs were $2,769, compared with $4,208 for COBRA costs (chart 1).

Chart 1

SEVEN YEARS OF ADVERSE SELECTION: AVERAGE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) COSTS PER PARTICIPANT, PLAN YEARS 1990-1996



Source: Stephen A. Hugh, "COBRA Costs Continue to Be High, Erratic," *Employee Benefit Plan Review* (September 1997): 36–44.

Another study also found some evidence that COBRA beneficiaries used more health care than active workers.[8] This study examined claims data from three large employer health plans, and found that COBRA costs ranged from 32 percent to 224 percent higher than health care costs for active workers. For one plan, these differences were due entirely to demographics, with COBRA beneficiaries being much more likely to be women of child-bearing age. These data would suggest that allowing employers and insurers to set COBRA premiums based on risk-adjusted factors, such as demographics, would reduce the level of adverse selection.

While data on COBRA elections and limited data on the size of the COBRA population are available, virtually no data exist on COBRA beneficiaries themselves. For policy purposes, it is important to understand the characteristics of the COBRA population and how this population differs from the rest of the population. In order to gain a better understanding of the COBRA population, we used data from the 1993 panel of the Survey of Income and Program Participation (SIPP). SIPP is a longitudinal study that follows individuals for 36 months. Combining waves 6 through 9 of the 1993 panel allows the observation of individuals over a 12-month period. This 12-month period, October 1994-September 1995, represents the most recent SIPP data that allow researchers to track the entire sample for 12 months.[9]

Because the COBRA population is examined over a 12-month period, it is impossible to determine the full duration of each spell. Some spells may have begun before October 1994, while others may have ended after September 1995. As a result, we separate COBRA beneficiaries into two groups—those with COBRA coverage for the entire 12-month period and those with COBRA coverage for less than 12 months—with the understanding that the latter group may in fact have had COBRA coverage for 12 months or longer. Our analysis sample represents 0.6 million individuals with COBRA coverage for 12 months between October 1994 and September 1995, 4.4 million individuals with COBRA for less than 12 months, and 59.2 million individuals with employment-based health insurance coverage in their own name for the entire 12-month period.

As you can see from table 1, the COBRA population is much older than the population of individuals with employment-based coverage through their current employer. While we may be capturing a retirement effect, meaning older individuals use COBRA as a bridge to Medicare coverage, we find similar results when limiting the analysis to workers. COBRA beneficiaries are also more likely than individuals with coverage through a current employer to be male, married, white, have no children under age 18, and to have a graduate school education. They are also less likely to be working.

Table 1

CHARACTERISTICS OF PERSONS AND WORKERS AGES 18–64 WITH 12 MONTHS OF CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) COVERAGE, LESS THAN 12 MONTHS OF COBRA COVERAGE, AND 12 MONTHS OF EMPLOYMENT-BASED COVERAGE IN OWN NAME, OCTOBER 1994–SEPTEMBER 1995

	Persons Ages 18–64			Workers		
	COBRA 12 months	COBRA 1–11 months	Employment-based coverage in own name 12 months	COBRA 12 months	COBRA 1–11 months	Employment-based coverage in own name 12 months
Age						
18–24	1%	11%	6%	2%	13%	6%
25–34	5	27	29	7	29	29
35–44	6	23	33	5	24	33
45–54	20	19	23	17	18	23
55–64	68	19	9	69	17	9
Gender						
Male	67	55	59	70	57	59
Female	33	45	41	31	43	41
Marital Status						
Married	76	55	62	79	55	62
Widowed	4	3	2	7	2	2
Divorced	11	14	13	3	12	13
Separated	4	3	3	2	4	3
Never married	6	26	21	9	27	21
Race						
White	94	82	81	94	82	80
Black	5	7	9	4	8	10
Hispanic	1	8	7	2	7	7
Other race	0	3	3	0	3	3
Number of Own Children Under Age 18						
None	93	67	58	89	65	58
One	5	14	17	9	14	17
Two	1	13	17	0	14	17
Three or more	1	6	8	2	7	7
Education						
Some school	12	10	9	7	8	8
High school	36	29	34	33	28	32
College	32	46	43	37	48	44
Graduate school	19	15	15	22	15	16
Household Type						
Married couple	76	61	66	79	62	67
Male head	0	2	3	0	1	3
Female head	9	12	11	5	11	11
Other male	5	13	11	5	12	11
Other female	10	12	9	11	13	9
Group quarters	0	0	0	0	0	0
Number of Jobs						
One job	52	64	95			
Two jobs, all month	2	2	3			
Two jobs, not all month	0	2	0			
Two jobs, no overlap	0	2	0			
No job	46	30	2			

Source: Employee Benefit Research Institute estimates from the 1993 panel of Survey of Income and Program Participation, Waves 6–9.

With respect to income, 12-month COBRA beneficiaries have higher personal income than the population with insurance coverage through their current employer (table 2). This difference is almost entirely due to differences in other personal income, which includes retirement income. This would suggest that retirees are using COBRA as a bridge to Medicare. However, workers are also more likely to be using other personal income for COBRA coverage. In both cases, the total population and workers had higher average asset income than persons with employment-based coverage through their current employer.

Table 2

SOURCES OF INCOME OF PERSONS AND WORKERS AGES 18–64 WITH 12 MONTHS OF COBRA COVERAGE, LESS THAN 12 MONTHS OF COBRA COVERAGE, AND 12 MONTHS OF EMPLOYMENT-BASED COVERAGE IN OWN NAME, OCTOBER 1994–SEPTEMBER 1995

	Persons Ages 18–64			Workers		
	COBRA 12 months	COBRA 1–11 months	Employment-based coverage in own name 12 months	COBRA 12 months	COBRA 1–11 months	Employment-based coverage in own name 12 months
Total Income						
Less than $10,000	14%	15%	2%	9%	8%	2%
$10,000–$19,999	24	31	21	15	34	21
$20,000–$29,999	15	24	28	17	25	29
$30,000–$39,999	15	14	21	17	17	21
$40,000–$49,999	7	8	13	7	8	13
$50,000 or more	25	8	16	35	9	16
Earned Income						
Less than $10,000	54	30	2	39	22	2
$10,000–$19,999	17	29	23	22	31	23
$20,000–$29,999	8	19	29	13	22	29
$30,000–$39,999	11	12	20	12	14	21
$40,000–$49,999	1	4	12	2	5	12
$50,000 or more	9	5	15	13	6	14
Asset Income[a]						
Less than $10,000	97	98	99	97	99	99
$10,000–$19,999	1	2	1	4	1	1
$20,000–$29,999	2	1	0	0	1	0
Other Income[b]						
Less than $10,000	29	85	98	26	87	98
$10,000–$19,999	40	9	1	38	5	1
$20,000–$29,999	17	5	0	21	6	0
$30,000–$39,999	9	1	0	10	1	0
$40,000–$49,999	5	1	0	3	0	0
$50,000 or more	1	0	0	2	1	0
Total Family Income						
Less than $10,000	4	4	0	4	2	0
$10,000–$19,999	11	14	8	7	16	8
$20,000–$29,999	20	18	14	12	16	14
$30,000–$39,999	17	19	16	16	20	17
$40,000–$49,999	8	13	16	7	15	16
$50,000 or more	40	32	46	53	31	45

Source: Employee Benefit Research Institute estimates from the 1993 panel of Survey of Income and Program Participation, Waves 6–9.

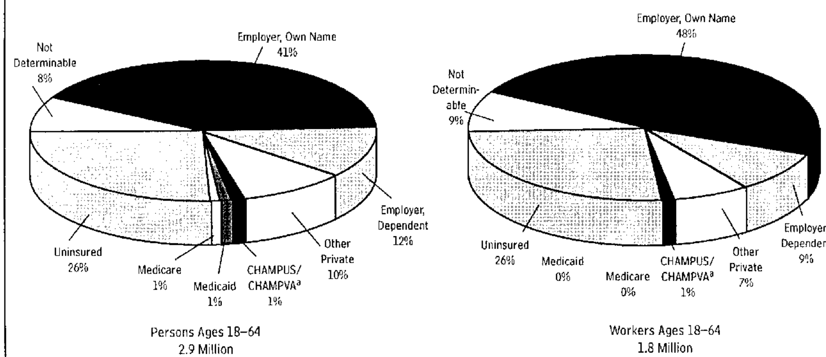
[a]Asset income includes interest from savings accounts, money market funds, securities, and bonds; stock dividends received and reinvested; net rental income, mortgage interest, and royalties or other investment income.

[b]Other income includes Social Security, railroad retirement, unemployment compensation, supplemental employee benefits, veterans' compensation, workers' compensation, employer or union temporary sickness payments, disability insurance, child support, alimony, private or public pension income, annuity income, and other cash income not included elsewhere. It does not include means-tested cash transfer payments.

Previous research has been unable to determine what happens to COBRA beneficiaries after COBRA benefits end.[10] Using SIPP, we can determine the health insurance status of COBRA beneficiaries after they leave COBRA. According to chart 2, 41 percent of persons ages 18–64 received coverage in their own name from their own employer after leaving COBRA. An additional 12 percent received employment-based coverage as a dependent. Ten percent purchased private coverage on their own. Twenty-six percent became uninsured. The same general pattern can be seen for workers leaving COBRA coverage, with 48 percent returning to employment-based coverage in their own name, 9 percent gaining coverage as a dependent, 7 percent purchasing private coverage on their own, and 26 percent becoming uninsured.

Chart 2

SOURCES OF COVERAGE AFTER CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) COVERAGE PERSONS AND WORKERS AGES 18–64 WHOSE COBRA SPELL ENDED DURING SURVEY



Source: Employee Benefit Research Institute estimates from the 1993 panel of Survey of Income and Program Participation, Waves 6–9.
[a]Civilian Health and Medical Program of the Uniformed Services/Civilian Health and Medical Program of the Veterans Administration.

The Health Insurance Portability and Accountability Act of 1996

Portability was also the goal of legislation passed in 1996. HIPAA established greater portability of health insurance in that it prohibits group health plans from imposing preexisting condition exclusion periods on individuals with a history of prior health insurance coverage. HIPAA did not ensure that a worker who changes jobs will have access to health insurance coverage on the new job, and did not ensure that health insurance on a new job would be affordable. In addition, HIPAA did not allow individuals to maintain the same group health plan after a job change. When a worker changes health plans on job change, there is a chance that he or she may well have to change health care providers, and there is also a high chance that the benefits package will be different; therefore, "total" portability is not achieved.

Health insurance would be totally portable if a worker did not have to change health plans on job change. In order to understand portability, a brief examination of pension plans is helpful. All pension plans are portable in that they allow "vested" workers to keep accumulated assets on job change.[11] For example, if a worker with a defined contribution plan changes jobs, the amount accumulated in the account could be rolled over into a qualified individual retirement account and, in some cases, into the new employer's pension plan. Keeping this definition of portability in mind, HIPAA did not make health insurance totally portable. HIPAA "improves" portability as it makes it easier to get new health insurance on job change for individuals with preexisting conditions. In contrast, COBRA "guarantees" portability, as it allows workers to maintain their current health insurance plan.

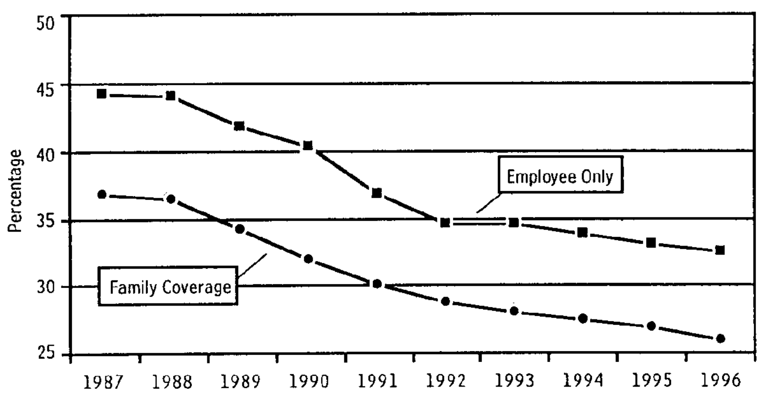
CONCLUSION

HIPAA included provisions that directly affected COBRA by clarifying eligibility criteria for newborns and adopted children and individuals with disabilities. These were minor changes to COBRA. More important, however, is the fact that HIPAA may indirectly result in more individuals electing COBRA coverage, and may result in individuals keeping COBRA coverage for longer periods. HIPAA allows individuals who keep their coverage in effect to avoid preexisting condition waiting periods, and guarantees access to health insurance coverage in the individual market after COBRA benefits have been exhausted. These HIPAA provisions combined with any attempt to expand COBRA coverage further, either through subsidies or by allowing workers to choose from plans with lower premiums, will likely result in increased employer health care costs. Survey data indicate that the primary issue concerning COBRA is its impact on claims experience and administrative costs for active employees, employers, and COBRA beneficiaries. If the cost issues are not addressed with future COBRA expansions, employers may consider various alternatives to reduce, shift, or eliminate the impact of this increased cost.

One alternative is for employers to continue requiring active employees to share in the increased costs through higher employee contributions. Since at least 1987, employers have been increasingly shifting the cost of health insurance coverage onto workers. In 1987, 44.2 percent of workers with employee-only coverage had that coverage fully financed by their employer, compared with 32.5 percent in 1996 (chart 3). In addition, 36.7 percent of workers with family coverage had that coverage fully financed by their employer, compared with 25.9 percent in 1996. As the employee share of health insurance premiums increases, active employees increasingly pay part of the cost of adverse claims experience under COBRA (above the 102 percent of premium/cost allowed) because former employees and their families under COBRA are not paying the true cost of the coverage they are receiving.

Chart 3

PERCENTAGE OF PERSONS WITH EMPLOYMENT-BASED HEALTH INSURANCE IN OWN NAME WHOSE EMPLOYER FULLY FINANCED HEALTH INSURANCE, 1987–1996



Source: Employee Benefit Research Institute estimates from the March 1988–1997 Current Population Surveys.

A second alternative is to reduce or eliminate health care benefits for active employees and/or future retirees and their families, thereby reducing or eliminating the COBRA continuation coverage. This might be a particularly attractive option for small employers, who are already experiencing high health insurance premiums. In addition, small employers are not as likely as large employers to absorb cost increases. The reduction in coverage shifts a greater share of the cost to employees, but elimination of coverage obviously exacerbates the problem of access to health insurance.

A third alternative is to reduce the size of the work force eligible for health insurance benefits. Employers could accomplish this by substituting part-time workers for full-time workers or by increasing the hours worked by full-time workers. One study found that the increased use of part-time workers as a percentage of the labor force accounted for 7 percent of the decline in employment-based health insurance between 1988 and 1993.[12] Furthermore, another study found that hours of work increased for workers with health insurance by 0.06–0.10 hours per week, compared with workers without health insurance.[13] The study also found that hours of work increased more rapidly in industries with relatively high health insurance costs.

Finally, where possible, the employer may pass additional costs along to workers or consumers. Workers could be affected if wage increases are not as large as they would have been if COBRA costs were not an issue. Consumers would be affected if employers raised product prices, creating additional inflationary pressure in the economy.

The survey data and the alternatives available to employers to deal with increased medical plan costs suggest that some changes to COBRA may be necessary. An increase in the percentage of the premiums allowed to be charged to COBRA beneficiaries may be in order to accommodate the higher level of claims costs associated with COBRA beneficiaries. The Clinton administration has recognized this idea in its FY 1999 budget proposal. One provision of the proposal would define another COBRA qualifying event as occurring for current retirees when an employer drops retiree health benefits. This provision would allow retirees to elect COBRA coverage, but employers would be allowed to charge 120 percent to 125 percent of the premium. Any such increase should consider both the current impact COBRA claims are having on employers and COBRA beneficiaries' ability to continue the coverage if the premium becomes too high. Another alternative would be to reduce the length of time coverage is required to be offered. A shortened rather than lengthened COBRA coverage continuation period could help reduce employers' administrative costs. While those most likely to be affected are former employees' families, the survey data indicate that the majority of COBRA beneficiaries would not be adversely affected. The longer-term loss of coverage problem could be dealt with as part of the larger overall problem of health care access, costs, and quality. However, with COBRA and HIPAA generating a relatively large-scale debate over legislation that does very little to affect coverage levels, even larger scale reforms concerning health care access, costs, and quality will likely be that much more difficult to accomplish.

Madam Chair, this concludes my statement. Thank you for the opportunity to testify this afternoon. I would be happy to answer any questions that you or members of the committee might have.

ENDNOTES

1. Paul Millholland, "Employers' COBRA Costs," EBRI Notes, No. 11 (Employee Benefit Research Institute, November 1992): 1–4.

2. The Supreme Court is going to consider the case when a qualified beneficiary already has other health insurance coverage. The dispute concerns whether individuals who have other health insurance coverage prior to the COBRA qualifying event are eligible for continuation of coverage under COBRA.

3. Adverse selection occurs when higher-risk individuals are more likely to seek health insurance coverage than low-risk individuals.

4. Stephen H. Long and M. Susan Marquis, "COBRA Continuation Coverage: Characteristics of Enrollees and Costs in Three Plans," in Health Benefits and The Workforce, U.S. Department of Labor, Pension and Benefits Welfare Administration (Washington, DC: U.S. Government Printing Office, 1992).

5. Jacob Alex Klerman and Omar Rahman, "Employment Change and Continuation of Health Insurance Coverage," in Health Benefits and The Workforce, U.S. Department of Labor, Pension and Benefits Welfare Administration (Washington, DC: U.S. Government Printing Office, 1992).

6. Jonathan Gruber and Brigitte C. Madrian, "Non-Employment and Health Insurance Coverage," Journal of Public Economics, forthcoming.

7. Dual labor market theory suggests that there are two noncompeting labor markets: a primary sector that offers relative high wage, stable jobs that include employee benefits, and a secondary sector that tends to be low-wage and unstable. This theory would indicate that workers with health insurance who change jobs are likely to get another job with health insurance, but workers without health insurance tend not to gain health insurance on job change. See P. B. Doeringer and M.J. Piore, Internal Labor Markets and Manpower Analysis (Lexington, MA: DC Health, 1971).

8. Stephen H. Long and M. Susan Marquis, "COBRA Continuation Coverage: Characteristics of Enrollees and Costs in Three Plans," in Health Benefits and The Workforce, U.S. Department of Labor, Pension and Benefits Welfare Administration (Washington, DC: U.S. Government Printing Office, 1992).

9. SIPP does not allow researchers to make a distinction between retiree health benefits and COBRA coverage. The health insurance question asks respondents to report the source of health insurance coverage, but limits the answers to current employer, former employer, or other. In order to make the distinction between retiree health benefits and COBRA coverage, data from the September 1994 CPS Population Survey were used to impute COBRA coverage for individuals ages 40–64. All individuals under age 40 were assumed to have COBRA coverage. SIPP also does not allow researchers to identify spouses and dependents with COBRA coverage; therefore, the population estimates presented in this paper should be considered a lower bound estimate.

10. COBRA benefits will end either because the person has exhausted the benefits or stopped paying for the benefit before the 18-month benefit period was reached.

11. For workers with a defined benefit plan, job change may result in a loss of potential benefits. Defined benefit plans typically base benefits in part on years of service. As a result, workers who change jobs may not be credited for past service with former employers. In addition, full vesting of pension benefits does not usually occur immediately for plan participants.

12. Paul Fronstin and Sarah C. Snider, "An Examination of the Decline in Employment-Based Health Insurance Between 1988 and 1993," Inquiry 33 (Winter 1996/97): 317–325.

13. David M. Cutler and Brigitte C. Madrian, "Labor Market Responses to Rising Health Insurance Costs: Evidence on Hours Worked," unpublished paper, October 1997.

The views expressed in this statement are solely those of the author and should not be attributed to the Employee Benefit Research Institute (EBRI), its officers, trustees, *sponsors, or other staff. The Employee Benefit Research Institute is a private, non-profit, nonpartisan, public policy research organization.*

Chairman JOHNSON. Thank you very much.
Mr. Klein.

STATEMENT OF JAMES A. KLEIN, PRESIDENT, ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS

Mr. KLEIN. Thank you, Madam Chairman. I know that both you and the APPWP, who I represent, have been doing double duty today. You have chaired this morning's Health Subcommittee meeting, at which we were privileged to testify, and we appreciate the opportunity to be at both Subcommittee hearings.

Madam Chairman and Members of the Subcommittee, my name is James Klein. I am president of the Association of Private Pension and Welfare Plans, the APPWP. Our members are principally large Fortune 500 companies and other organizations that provide benefit services to employers of all sizes. Collectively, our members either sponsor directly or administer health and retirement plans that cover more than 100 million Americans.

I hope that you will indulge me in two respects this afternoon. First, as you may know, today is National Take Your Daughter to Work Day, and both my 7-year-old daughter and 10-year-old daughter are here in the audience. So while I would be delighted to answer any questions at the conclusion of my prepared remarks, please make those questions easy since I only have 1 day a year to try to impress my kids. [Laughter.]

Second and more seriously, I ask the indulgence of the Subcommittee as I share a number of statistics about the employment-based health system. But these statistics support a compelling message. Namely, that the employer-sponsored health system provides vital health insurance protection to the majority of Americans, and employers are driving the movement toward higher quality health care services.

Congress is to be commended for consistently supporting the tax preferences accorded employer-sponsored benefits. It is a shining example of enlightened tax and social policy.

There are 160 million Americans who are covered by employment-based health plans, because that is the most efficient way for the market to provide those benefits. Clearly, the tax preferences, both the employer deductibility and the employee excludibility, are essential to sustain this voluntary system.

Without employer sponsorship, millions of people, especially low-income workers and their families, would be uninsured. And I think that goes directly to the point of the very moving letter that you, Congresswoman Thurman, read to the previous panel.

The Office of Management and Budget estimates that in fiscal year 1999 the tax expenditure for employer-sponsored health benefits will be $76 billion. While that is certainly a very large number, it really must be looked at in the context of the estimated $303 billion that employers will spend on their employees' health plans next year.

That means that for every dollar of tax expenditure, the Nation's employers will provide $3.90 of health benefits. This is a great bargain, not just for workers and their families, of course, but also for the Federal Treasury. What would otherwise cost the Treasury $303 billion if these benefits were directly publicly financed, instead costs $76 billion by providing it through employers.

Of course, the benefits of the tax exclusion go well beyond just the dollars involved. The employer-based health care financing system also alleviates many of the problems that afflict the individual health insurance market, such as adverse risk selection, less than optimal purchasing of health care services, and high administrative costs which the witnesses on the earlier panel so ably discussed.

APPWP recognizes, as do you, Madam Chairman, that for all the many advantages of employer-sponsored health benefits, many individuals must obtain insurance on their own because they are not covered by an employer plan. You have wisely sought to address this problem, Madam Chairman, by introducing H.R. 3475 to extend tax-favored treatment to individually purchased health coverage.

APPWP has consistently supported full deductibility for health coverage purchased by self-employed individuals. Similarly, we believe that H.R. 3475 deserves prompt and serious consideration. As the Committee considers the bill, you will want to ensure that expanding individual deductibility does not unintentionally provide an incentive for employers to decline sponsoring a plan.

We applaud you for recognizing that fair and equitable tax treatment of individually purchased health benefits is also sound tax policy, and it can and should be developed without disrupting the group market. We welcome the opportunity to work with you on this matter.

Allow me to conclude then by briefly but emphatically underscoring that Congress must resist proposals that add cost to the sponsorship of health plans. Currently, an astounding 40 million of our fellow citizens are uninsured. Ill-advised policies, however well-intentioned, will worsen that problem. The cost of health care is the single greatest impediment to greater coverage. For every 1-percent increase in the cost of health insurance, 400,000 Americans lose coverage.

For years, State legislatures have contributed to this problem by adopting a variety of costly benefit mandates. Regrettably, this trend has now found favor here in Congress. This is frankly perplexing to those employers, such as every member of APPWP, who are committed to providing health coverage to their employees.

Just 4 years ago, Congress rejected the notion that all employers should be required to provide health coverage. Now, however, there is broad support for a variety of proposals to mandate that those employers who voluntarily offer coverage must provide certain types of benefits.

Ironically, whereas Congress rejected the idea of mandated coverage advocated by the Clinton administration in 1994, it embraced the concept of mandated specific benefits in 1996 with the passage of mandates related to mental health benefits and minimum hospital length of stay following childbirth.

To summarize then, I must note that, by definition, a benefit mandate is only directly imposed on those employers who provide health insurance protection to their work force. Those who sponsor health plans are penalized for doing so when costly mandates are enacted. But those employers who find it difficult to provide coverage for all the reasons stated by the earlier witnesses are also given further economic disincentives to do so.

On behalf of the companies that I represent, I urge Congress to resist the temptation to become the Nation's employee benefits manager and to focus instead, as you are doing, Madam Chairman, on practical steps to extend coverage to the uninsured.

Thank you for this opportunity to testify. I'd be pleased to answer any questions.

[The prepared statement follows:]

Statement of James A. Klein, President, Association of Private Pension and Welfare Plans

Madam Chairman and members of the Subcommittee, my name is James A. Klein. I am the President of the Association of Private Pension and Welfare Plans (APPWP—The Benefits Association), a national trade association of companies concerned about the employee benefits system. APPWP's members include Fortune 500 companies and other organizations that provide benefit services to employees. Collectively, APPWP's members either sponsor or administer health and retirement plans covering more than 100 million Americans. Our members take very seriously their role in providing health care coverage for their employees and family members, and are keenly interested in the laws, including the tax provisions, that are the foundation of employer-sponsored health plans. I would like to use this opportunity to provide the subcommittee with data concerning the employer-sponsored health benefits system, as well as our perspective on the importance of the tax preferences accorded to that system.

OVERVIEW

Over 60 percent of all Americans, and almost 65 percent of Americans under the age of 65, receive some or all of their health insurance benefits through an employer-sponsored plan. One hundred and sixty million Americans are covered by employment-based health plans because that is the most efficient way for the market to provide those benefits. (see Table 1)

Table 1. Source of Health Insurance Coverage, 1996

	Total		Nonelderly		Elderly	
	Individuals	Percent	Individuals	Percent	Individuals	Percent
Total	265,926,692	100%	234,049,354	100%	31,877,338	100%
Total Private	187,052,082	70%	165,828,529	71%	21,223,552	67%
Employer	160,771,239	60%	149,822,955	64%	10,948,284	34%
Direct	85,478,208	32%	76,913,340	33%	8,564,867	27%
Indirect	75,293,031	28%	72,909,614	31%	2,383,417	7%
Other Private	26,280,843	10%	16,005,575	7%	10,275,268	32%
Total Public	68,133,929	26%	37,420,022	16%	30,713,907	96%
Medicaid	31,441,940	12%	28,226,604	12%	3,215,336	10%
Uninsured	41,715,507	16%	41,379,413	18%	336,094	1%

Source: Tabulations of the March 1997 supplement to the Census Bureau's Current Population Survey
Note: The total for insurance categories may exceed 100% because individuals may have multiple sources of coverage.

In 1954 common accounting practice was codified when legislation was enacted clearly excluding employer contributions for health benefits from employees' taxable income. The Office of Management and Budget estimates that the revenue loss resulting from the exclusion of employer contributions for employee health benefits from the employees' taxable income to be $76 billion in fiscal year 1999. While that is a very large number, it needs to be looked at in the context of the $303 billion that employers will spend on their employees' health plans in fiscal year 1999. That means that next year for every $1 of tax expenditure for employer-sponsored health insurance, America's employers will provide $3.90 worth of health benefits to their employees and family members. This is quite a bargain for the nation's workers and their families, as well as for the federal Treasury. What would cost the Treasury—and the taxpayers who support it—$303 billion if these benefits were directly publicly financed, instead costs $76 billion in foregone revenue, by encouraging employers to offer this vital protection. And the bargain enjoyed by both the government and plan participants has remained essentially constant even as the health care system and the amount spent on health care have changed over the years.

However, the benefits of the tax exclusion accorded employer-sponsored health benefits go well beyond just the dollars that employers spend on their employees' health benefits. As described below, the employer-based health care financing system also alleviates many of the problems that currently afflict the individual health insurance markets: adverse risk selection, less than optimal purchasing of health care services, and high administrative costs.

We recognize, as do you Madam Chairman, that for all the many advantages of the employer-sponsored health benefits system, many individuals must obtain health care coverage on their own. Fair and equitable tax treatment of individually-purchased health benefits is also sound tax policy, and can and should certainly be developed without disrupting the group market. APPWP has supported full deductibility for health coverage purchased by self-employed individuals. We look forward to working with you and other members of the Ways and Means Committee on ensuring that the needs of both the individual and the group market are properly addressed.

RISK POOLING

The employment-based health system allows risks to be pooled more broadly than an individual insurance market can sustain. An individual's choice of health insurance coverage in an individual market is determined by an assessment of their own risks and income. As a result, those with the greatest demand for health insurance are those most likely to use health care services. Premiums in the individual market are therefore necessarily higher to cover the costs of the greater risks.

By contrast, employer health plans are offered to employees and their dependents as a portion of a compensation package. The individual's self assessment of their own risk, and how well a prospective employer's health plan protects them from that risk, is only one of a set of factors that lead them to accept or reject a job offer. Consequently, more good risks are part of an employer's risk group arrangement reducing the effective premium and making employment-based health insurance more cost effective that the alternatives.

The exclusion of the value of employer contributions for health benefits from employees' income for tax purposes lowers the effective costs of health insurance for employees and increases health insurance coverage. Tying the exclusion expressly to employment-based plans provides an incentive to make that health insurance purchase cost-effective—further increasing health insurance coverage.

If the tax exclusion were removed, the result would be to increase dramatically the effective price of health insurance. The healthier individuals would be the first to drop their coverage, resulting in a riskier employer pool and raising the costs of coverage even more for those still purchasing coverage.

Estimates of the impact vary, but they all imply an enormous loss of health insurance coverage would result from a limit on, or removal of, the tax exclusion for employer health benefits. Researchers investigating a proposal that would cut the value of the exclusion by half estimated that between 8.6 and 14 million people would lose health insurance coverage (Gruber and Poterba, 1997). Another researcher estimated that removing the exclusion would increase the number of uninsured Americans by at least 16 million. (Cutler,1997). It is important to note that those most likely to lose coverage would be low income workers and their families.

HEALTH CARE PURCHASING

From the beginning of World War II until the early 1980s both the number of people receiving employment-based health insurance coverage and the scope of that coverage expanded. This expansion, together with the introduction of the Medicare and Medicaid programs in 1965, greatly increased the number of Americans with health insurance. It also produced an inflationary push in the cost of health coverage that has created an evolutionary pull in both the health services market and the employment-based financing system.

Health care cost inflation gradually changed the dynamics of the health care financing system. National health expenditures have consistently risen faster than national income at least since 1960. In that year, national health expenditures accounted for about 5 percent of Gross Domestic Product (GDP). By 1996, national health expenditures had nearly tripled to just under 14 percent of GDP.

Yet the *rate* of growth in national health care expenditures has slowed in recent years. This moderation of health care cost inflation occurs after a decade of rapid evolution in the health care delivery system, both in terms of technological innovation, and in the organization and financing of the delivery of health care services.

Employment-based plans have provided much of the impetus for the evolution of the health care system. Employers offer health benefits to attract and retain their desired workforce. Employers gain a competitive advantage if they can offer their employees a higher quality health plan at a lower cost than their competitors. As a result, employers have a strong incentive to seek out and purchase cost-effective care. Moreover, because their goal is to attract and retain workers, employers have an incentive to tailor their plans to fit the needs of their employees.

Employer attempts to manage health care cost inflation have focused on two issues: reducing the amount of waste in the health care delivery system and applying cost-benefit criteria to the introduction of new technology. Measuring the amount of waste in the system, or the benefits of any health care procedure, requires an ability to measure the effect of health care on a patient, or a population.

The need to evaluate health plans and health care providers for selective contracting, and to evaluate care as it is being provided, has led to the development of a health information industry. This industry supplies providers, insurers, employers, and consumers with information on the quality, appropriateness, and cost effectiveness of the care they are producing or consuming. Employers, specifically, established the Health Plan Data Information Set (HEDIS) to meet their needs for valid measurements of such criteria as quality and cost effectiveness; and this has certainly led to the growth of this health information industry. Quality assessment methods continually are being developed and implemented for measuring health service outcomes and patient satisfaction, and evaluating competing physicians, hospitals, and health plans. This industry is still very much in its infancy with much work yet to be done before the health care market is optimally efficient; but it is unlikely to have existed at all without the demand for it from employers.

Administrative Costs

One of the advantages of an employer-based health plan is the ability to spread the administrative costs over the entire insured group, which leads to significant savings for individuals within the group. These costs include marketing, enrollment, and claims processing. It has been estimated that the cost of an individual health policy is 30 percent higher than a similar group health policy due to administrative costs alone. (Thorpe, 1992, Congressional Research Service, 1988).

Economists have long recognized that the cost of information is one of the barriers to an efficient health care delivery system. Employers significantly reduce the costs that individuals on their own would incur in gathering information about health plans and providers. Moreover, employers can spread those costs over their entire workforce. While an individual will often find it difficult to allocate enough time to gather the data needed to make informed choices, employers, especially large companies, typically employ benefits professionals who are experts in health care and health insurance and in communicating this information to company employees. Employers are also able to supplement their own services in these areas with those of professional benefit consulting firms with highly sophisticated knowledge of health plan operations.

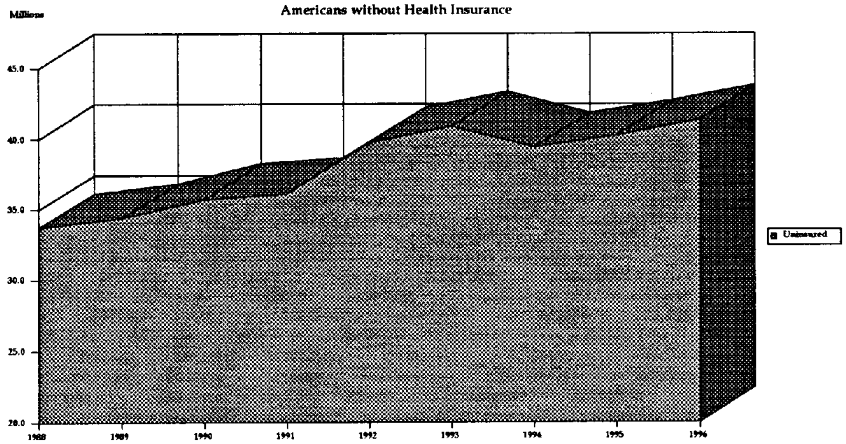
Challenges Facing Employment-Based Health Insurance

Costs

As health care costs increased and became a larger component of total compensation, the focus of employment-based plans moved from expanding coverage to containing costs. Moreover, the increase in health costs began to reduce the number of employers, especially smaller employers, who could afford to offer coverage and reduce the number of workers who elected to participate in their employer's health benefits plans.

The number of Americans without health insurance increased slowly throughout the 1980s and then grew sharply during the economic downturn at the beginning of the 1990's. Since 1993 the percentage of Americans who are uninsured has remained fairly constant despite strong economic growth. The latest data available indicates that 18 percent of Americans (over 41 million) under the age of 65 are without health insurance. (See Chart 1)

Chart 1
Americans without Health Insurance



The reason for the increase in the number of Americans without health insurance is primarily the increase of health care costs relative to family income. As these costs increase, families decrease their purchase of health care services and especially health insurance. Insurance is a hedge against the likelihood that an individual or a family will need health care services. Those who are most likely to reduce their purchase of health insurance are those whose family income or perceived risk of needing health care services are low.

Of course, one of the most disturbing results of this reality, is that lower income families who feel economically compelled to decline coverage, are precisely the families who have fewer financial resources to draw upon when they become ill and lack either sufficient, or possibly any, insurance to cover their health care costs. While the lack of coverage for these individuals is at best a daunting prospect, and at worst a potential personal financial catastrophe, the rest of us either as taxpayers or as health care consumers fortunate enough to have health care coverage are also directly affected negatively. When people who are uninsured receive health services, the costs are borne by various taxpayer-financed public programs or by health care providers who, where possible, pass those costs on to employers and other health care consumers with the resources to pay for services. This, of course, makes the cost of health insurance more expensive for those who have it.

In pure economic terms, to say nothing of the human dimension, it would be far preferable for the government to bear the cost of the tax expenditure for employer-sponsored or individual health coverage for those who currently lack coverage, than to pay directly for so-called uncompensated care through public programs. To the extent that the health care costs of the uninsured fall to individuals who must purchase health insurance, or pay directly for health services in a non-tax favored manner, they are bearing an added cost. Even for employers who may deduct whatever added cost they bear for paying for health services for the uninsured; the added cost imposed on them still makes health care more expensive for these employers and their employees.

Mandates

This discussion of the uninsured is relevant to this subcommittee's oversight because the tendency of state governments, and in recent years the federal government, to mandate certain benefits has increased the cost of coverage which has led to more uninsured Americans.

In an effort to extend either the scope of coverage or the number of individuals with health insurance coverage, policy makers have imposed a number of mandates on employment-based health insurance. The power to limit or deny the tax-favored treatment of employer-sponsored benefits has proven to be an effective mechanism to enforce some of these mandates. However effective these mandates may be in achieving their intended purposes, they typically have had the unintended consequence of increasing the costs of health plans and thus reducing health insurance coverage.

Mandates at the state level—applied primarily to fully insured health plans—have existed for some time. But more recently they have found favor here in Congress, as well, through the enactment of specific benefit mandates. This apparent willingness by Congress to mandate benefits is frankly perplexing to those employers—such as every member of the APPWP—who are committed to providing health coverage to their employees. Just four years ago during the debate over comprehensive health care reform, Congress completely rejected the notion that all employers should be required to provide health coverage to all full-time employees. Now, however, there is broad support among many in Congress for legislation to mandate that those employers who voluntarily offer health coverage to their employees must provide certain types of benefits. Whereas Congress rejected the idea of mandated coverage advocated by the Clinton Administration in 1994, it embraced the concept of mandated specific benefits in 1996 with passage of mandates related to mental health benefits and minimum hospital lengths of stay following childbirth. By definition, a benefit mandate is only imposed on those employers who provide health insurance coverage to their workforce; so those who sponsor coverage are penalized for doing so, and those who do not provide coverage are given further economic disincentives to begin doing so.

Perhaps the foremost example of how mandates impose additional costs on employers and thereby cause plan participants to lose health coverage, is the one mandate that at the time of enactment was purported to be paid for by participants and which was intended specifically to prevent people from losing coverage. The health care continuation provisions of the Consolidated Budget Reconciliation Act of 1985 (COBRA) require employers to allow employees and their dependents who would lose health insurance coverage due to job loss or change in marital status to remain in their group health insurance plan for a specified number of months. Employers are allowed to charge a premium of not more than 102 percent of the actual premium charged to active employees. However, the actual costs of providing coverage to individuals who elect COBRA is approximately 50 percent higher than the average cost of providing coverage to active employees. (Spencer's Employee Benefits Survey, September 1997). The difference between the premium charged and actual costs are borne by the employer and all employees in the plan. The relationship between higher costs and more uninsured is not theoretical. Researchers have found that while the number of workers offered health insurance by their employers has increased slightly over the last decade, the number of workers who turn-down that coverage has more than doubled over the same period. In 1996, six million workers declined health insurance from their employer, largely because of costs (Cooper and Schone, 1997). Another study determined that a one percent increase in the cost of health insurance results 400,000 Americans losing health insurance coverage (Lewin, 1997).

SUMMARY

The employment-based health insurance system is the foundation of the health care delivery system. It allows most Americans an opportunity to attain high quality cost-effective health insurance that they otherwise could not purchase. Employers, responding to changing economic conditions, have spurred a rapid evolution in the health care delivery system. Yet this system faces important challenges. Long-established tax policy has made it possible for employers to be able to afford to sponsor health benefit plans, and has made it economically beneficial for workers, especially low income workers and those who might otherwise risk being unprotected, to accept such coverage. The result has been a system that covers more than 160 million Americans.

Despite the enormous success, adverse public policy initiatives have added to costs, reduced the number of employers, especially small employers, that offer health insurance as an employee benefit and increased the number of Americans who feel compelled to decline coverage even when it is available through the workplace. These policies must be resisted by Congress to ensure the continuation of employer involvement in the health care system, with all of the benefits that that involvement means for both expanded coverage and for health care system innovation and quality improvement.

Thank you, Madam Chairman and members of the subcommittee. I would be pleased to answer any questions.

BIBLIOGRAPHY

Bureau of Labor Statistics, Employers Costs for Employee Compensation Summary, March 1997.

Cooper, Philip F. and Barbara S. Schone, More offers, fewer takers for employment-based health insurance: 1987 and 1996 Health Affairs, Vol. 16, no. 6 pp 142–49 (November, 1997)

Congressional Budget Office, Economic and Budget Outlook 1999–2008, Washington, DC

Congressional Research Service, Costs and Effects of Extending Health Insurance Coverage, Washington, DC, U.S. Government Printing Office, October 1988.
Cutler, David M, Comprehensive Tax Reform and Employment Based Health Insurance in Tax Reform: Implications for Economic Security and Employee Benefits Dallas Salisbury, ed. Employee Benefit Research Institute, Washington, DC, 1997
Employee Benefit Research Institute. "The Changing Health Care Delivery System: An EBRI/ERF Policy Forum." EBRI Special Report SR–21/Issue Brief No. 148 (Employee Benefit Research Institute, April 1994).
Field, Marilyn J. and Harold T Shapiro, eds, Employment and Health Benefits: A Connection at Risk Institute of Medicine, National Academy Press, Washington, D.C. 1993
Gruber, Jonathan and James Poterba, The Impact of Fundamental Tax Reform on Employment-Based Health Insurance in Tax Reform: Implications for Economic Security and Employee Benefits Dallas Salisbury, ed. Employee Benefit Research Institute, Washinton,DC, 1997
Miller, Robert H., and Harold S. Luft, "Managed Care Plan Performance Since 1980: A Literature Analysis," Journal of the American Medical Association, vol. 271, May 18, 1994, pp. 1512–1519.
Office of Management and Budget, Analytical Perspectives, Budget of the United States Government, Fiscal Year 1999 (Washington, DC U.S. Government)
Pauly, Mark V., "Taxation, health Insurance, and Market Failure in the Medical Economy," Journal of Economic Literature, vol. 24, June 1986, pp. 629–675.
Thorpe, K., Inside The Black Box of Administrative Cost, Health Affairs, 11(2): 41–55, 1992.

Chairman JOHNSON. Thank you very much.
Mr. Nelson, welcome.

STATEMENT OF WAYNE NELSON, PRESIDENT, COMMUNICATING FOR AGRICULTURE

Mr. NELSON. Thank you. Chairman Johnson and Members of the Subcommittee, thank you for the opportunity to testify on behalf of our members on issues related to tax policy and health insurance. My name is Wayne Nelson. I am president of Communicating for Agriculture, a national association of farmers, ranchers, and rural small business members in all 50 States.

our national headquarters are in Minnesota, where CA was founded 26 years ago. CA works on a variety of issues including health and tax policy and how it affects rural Americans. We have concentrated on ways to reduce costs and improve access to health coverage for our members.

We want to thank you for holding this hearing and for recognizing the current inequities in the tax law regarding the deductibility of health insurance premiums. We believe this is an opportune time for Congress to fix a longstanding injustice in tax policy that has discriminated against the self-employed and people who pay their own health insurance.

It is also an opportune time to extend and improve medical savings accounts. This health insurance concept holds much promise for providing another option for millions of people to help control their health costs while providing more choice at the same time.

Our members are predominantly self-employed, so they typically pay for all of their health insurance. This puts them at a disadvantage to employees who get their health insurance paid through their employers and trying to hold down the cost of health care and, in many cases, even having health insurance at all.

CA and many other organizations representing small business and agriculture have long fought to get the tax deduction for health insurance premiums raised to 100 percent. We recognize that a deduction for the self-employed is slowly increasing to reach 100 percent by the year 2007. But that's a long time to wait, especially when corporations can already deduct 100 percent of premiums.

In 1998, the self-employed will be able to use less than half, 45 percent of the allowable percentage of deductions allotted to corporations. The extra costs related to the lower deduction is very significant to many individuals and families who may pay hundreds or even thousands of dollars more in health costs than corporate employees.

There is no justifiable reason why the self-employed and others who pay for their own health insurance should only be allowed a partial deduction for health insurance premiums while large corporations can deduct the full amount.

Virtually everyone who has looked at the issue of the uninsured attribute the main reason to high cost. Too many individuals and small businesses simply cannot afford the cost of coverage. Studies have shown the lack of a full tax deduction and rising costs of coverage contribute to a higher rate of uninsured.

Numbers from the U.S. Census Bureau in 1996 reveal that over 60 percent of Americans covered have employment-based coverage. Less than 10 percent of people covered purchase their coverage individually. The reality is that far too often, individuals cannot afford individual coverage and opt to go uninsured.

There are also indications more small businesses facing higher costs for small group health insurance following various State and Federal regulatory insurance changes in recent years are increasing opting not to offer insurance to their employees. Rather than contending with the redtape, uncontrollable costs, and headaches of insurance programs, some small employers are simply offering their employees an additional monthly wage and are leaving the employees to buy their own insurance.

Additionally, corporate downsizing has increasingly led to individuals starting their own businesses, leaving them to face the challenges of obtaining affordable health insurance by themselves.

Congress has an excellent opportunity to accelerate the health insurance deduction for self-employed to 100 percent this year and correct inequities favoring corporations. Chairman Archer has indicated that legislation might be forthcoming accelerating the deduction, as well as expanding MSAs and possible other incentives for individuals in small businesses concerning health tax policy.

Representative Johnson has introduced H.R. 3475 which would offer the present tax deduction to all individuals who pay their own health insurance costs. It would also help the growing number of employees purchasing their own coverage due to the aforementioned corporate downsizing or employers opting to drop previously offered health care plans.

We support that effort. However, we also believe it is important that Congress move to accelerate the deduction allowed to 100 percent for everyone who pays their own health premiums.

The Senate is also looking at helping the self-employed and individuals gain health insurance tax equity with corporations. A bill has been introduced that would allow the first $2,000 of health premiums for a taxpayer, spouse, and dependent to be fully deductible. It would allow self-employed individuals to choose to use the current deduction or deduct the first $2,000 they spend in insurance premiums, whichever is more advantageous to the taxpayer.

Unfortunately, the bill does nothing to accelerate the slow phase-in to 100 percent.

The uninsured problem has always been more severe for people who work for small businesses or are self-employed. Congress must find ways to address their needs. CA believes that the ability of the self-employed and employees to help control their own health care costs makes the case for permanent MSA legislation.

The current MSA law was enacted as a 4-year pilot program. We'd like to see the caps removed on the number of MSAs that can be sold. We'd like to allow MSA deductible amounts to be adjusted to better fit the needs of policyholders, and we'd like to have both employers and employees contribute to an MSA.

If the Federal Government is serious about lowering the number of uninsured in the country, estimated to be over 40 million, then CA urges you to support the suggestions we have made in this testimony on accelerating the health insurance tax deduction for the self-employed and individuals and improving MSAs.

Thank you very much for the opportunity to address these important tax and health issues.

[The prepared statement follows:]

Statement of Wayne Nelson, President, Communicating for Agriculture

Chairwoman Johnson and members of the Subcommittee, thank you for the opportunity to testify on behalf of our members on issues related to tax policy and health insurance.

My name is Wayne Nelson. I am President of Communicating for Agriculture (CA), a national association of farmers, ranchers and rural small business members in all 50 states. Our national headquarters is in Minnesota, where CA was founded 26 years ago. CA works on a variety of issues including health and tax policy and how it effects rural Americans. We have concentrated on ways to reduce costs and improve access to health coverage for our members.

We want to thank you for holding this hearing and for recognizing the current inequities in the tax law regarding the deductibility of health insurance premiums. We believe this is an opportune time for Congress to fix a long standing injustice in tax policy that has discriminated against the self-employed and people who pay their own health insurance. It is also an opportune time to extend and improve Medical Savings Accounts. This health insurance concept holds much promise for providing another option for millions of people to help control their health costs while providing more choice at the same time.

Medical Savings Accounts are an innovative way for individuals to control their own health care costs. Medical Savings Accounts, enacted under recent legislation, offer an option to people who pay for their own health insurance to lower their costs by purchasing a less expensive, higher deductible, health policy and depositing the premium savings into an account to pay for routine and preventive medical care. The deposits would be tax deductible.

Our members are predominantly self-employed so they typically pay for all of their health insurance. This puts them at a disadvantage to employees, who get their health insurance paid through their employers, in trying to hold down the cost of health care and in many cases even having health insurance at all. CA and many other organizations representing small business and agriculture have long fought to get the tax deduction for health insurance premiums raised to 100 percent. We recognize that a deduction for the self-employed is slowly increasing to reach 100 percent by the year 2007, but that is a long time to wait—especially when corporations can already deduct 100 percent of premiums. In 1998, the self-employed will be able to use less than half (45%) of the allowable percentage of deductions allotted corporations.

The extra cost related to the lower deduction is very significant for many individuals and families who may pay hundreds or even thousands of dollars more in health costs than corporate employees. There is no justifiable reason why the self-employed and others who pay for their own health insurance should only be allowed a partial deduction for health insurance premiums while large corporations can deduct the full amount of insurance costs.

Virtually everyone who has looked at the issue of the uninsured attribute the main reason to high cost. Too many individuals and small businesses simply cannot afford the cost of coverage. Studies have shown the lack of a full tax deduction and rising cost of coverage contribute to a higher rate of uninsured. Numbers pulled from the U.S. Census Bureau in 1996 reveal that over 60 percent of Americans covered have employment-based coverage. Less than 10 percent of people covered purchased their coverage individually. The reality is that far too often individuals cannot afford individual coverage and opt to go uninsured.

There are also indications more small businesses facing higher costs for small group health insurance, following various state and federal regulatory insurance changes in recent years, are increasingly opting not to offer insurance to their employees. Rather than contending with the red tape, uncontrollable costs and headaches of insurance programs, some small employers are simply offering their employees an additional monthly wage and are leaving the employees to buy their own insurance. Additionally, corporate downsizing has increasingly led to individuals starting their own businesses—leaving them to face the challenges of obtaining affordable health insurance.

Congress has an excellent opportunity to accelerate the health insurance deduction for self-employed to 100 percent this year, and correct inequities favoring corporations. Chairman Archer has indicated that legislation might be forthcoming accelerating the deduction as well as expanding MSAs and possible other incentives for individuals and small business concerning health tax policy. Representative Johnson has introduced HR 3475, which would offer the present tax deduction to all individuals who pay their own health insurance costs. It would also help the growing number of employees purchasing their own coverage due to the aforementioned corporate downsizing and/or employers opting to drop previously offered health care plans. We support that effort. However, we also believe it is very important that Congress move to accelerate the deduction allowed to 100 percent for everyone who pays their own health premiums.

The Senate is also looking at helping the self-employed and individuals gain health insurance tax equity with corporations. A bill has been introduced that would allow the first $2000 of health premiums for a taxpayer, spouse and dependent to by fully deductible. It would allow self-employed individuals to choose to use the current deduction or deduct the first $2000 they spend in insurance premiums—whichever is more advantageous to the taxpayer. Unfortunately, the bill does nothing to accelerate the slow phase in to 100 percent tax deductibility for the self-employed.

The uninsured problem has always been more severe for people who work for small businesses or are self-employed. Congress must find ways to address their needs. CA believes that the ability of the self-employed and employees to help control their own health care costs makes the case for permanent MSA legislation. The current MSA law was enacted as a three year pilot program. Remove the caps on the number of MSAs that can be sold. Allow MSA deductible amounts to be adjusted to better fit the needs of policy holders. Let both employers and employees contribute to an MSA. Let anyone, who wants to, purchase this type of coverage.

If the federal government is serious about lowering the number of uninsured in the country, estimated to be over 40 million, then CA urges you to support the suggestions I have made in this testimony on accelerating the health insurance tax deduction for the self-employed and individuals, and improving MSAs. Thank you for the opportunity to address these important tax and health issues.

Chairman JOHNSON. Thank you very much for your testimony, and thank you, Mr. Nelson, for some of your suggestions as to other ways we could reach out into this market, particularly to help small employers provide affordable policies to their employees.

I was interested, Mr. Klein, in your testimony where you mentioned that for $76 billion in foregone revenues, that is, in tax expenditures, the private sector is spending $303 billion and for that is covering 160 million.

Bill Gradison, in a part of his testimony that he didn't actually read, mentioned that Medicare spends four times as much to cover two-thirds fewer people than the private sector. Now elderly people often have more costs, but I think it's very, very significant that Medicare is so much more costly for a smaller number of people and it bespeaks the tremendous problems that we do have in that system.

Mr. KLEIN. By the way, Madam Chairman, if I could just clarify. The number, the $76 billion and the $303 billion—your point is absolutely correct, but it does include both private and public employers, in other words, the Federal Government employees, State and local government employees, and so forth. Not public programs.

Chairman JOHNSON. The employee sector, yes. But I was very interested that a couple of you pointed to the movement in the small business sector to simply give employees more money rather than a group plan. Those are not the same things. I mean, if you give them more money, it doesn't necessarily let them buy into a group plan.

I'd like to hear your thoughts—all three of you, perhaps—on what kind of incentive effect we might get from making sure that all employers, subchapter S and all the little guys, had the 100-percent deductibility right away to encourage them to provide benefits to their employees as well as to themselves.

Would that be a very powerful incentive, in your experience in watching these issues out there, Mr. Nelson, in your community? Would that ability to completely deduct your premiums be an incentive for the very small business men to offer coverage to his two or three employees?

Mr. NELSON. We certainly think it would. And it would be one that would help stem this tide of small employers not offering the insurance. And if they had 100-percent deductibility sooner than the year 2007, it would certainly seem that they would be more willing to continue to offer the plan as a small employer. I know I would on my farm with my employees. The 100-percent deduction would certainly help to continue offering insurance to those people.

Mr. KLEIN. I would concur. It certainly would help. It's always hard to point to exactly what the results would be. Certainly there would still remain, it would seem, advantages of the employer system because of the active role that employers play in selecting health plans, pushing amongst health care providers for quality care, and just the benefits, of course, of group purchasing.

And I think some of the earlier comments that you heard about, the irony that a self-employed individual could deduct the expense for his or her employees, but not for him or herself currently, is a tremendous disincentive for that person.

Chairman JOHNSON. That is ironic, but most States have now—I mean, in our State, the biggest business organization has a group plan that very small employers can join. I think States have moved a long way, either through the Farm Bureau or some other group, to provide access to larger group plans for very small employers.

Presumably, they would have access to more affordable plans than their individual employees would have in the individual market. I was wondering, as we've made other changes, for instance when these larger group plans came on the market and made themselves available to smaller employers, did we see significant growth in small employer participation in the health benefit programs.

Mr. FRONSTIN. I think we have. I don't know that we could quantify it. Getting to your first question in terms of the incentive from the tax preference at 100 percent, I think there would be an incentive. I don't know if I would label it as a strong incentive, because there are other factors to consider if a small employer is going to offer health insurance, such as discrimination provisions.

We've looked at, from Census data, the cost-sharing arrangements across the spectrum of firm sizes and we see that for—and this is at the worker level, not the employer level—we see that for workers in small firms who have health insurance, their employer is more likely to fully finance the insurance than a worker who works for a large employer.

And one reason is the discrimination provisions which I believe say that the owner of a small business cannot benefit more from that plan than the employees.

Chairman JOHNSON. That's true in pension law. Is that true in health benefit law?

Mr. FRONSTIN. I have been told it is by a small business owner.

Chairman JOHNSON. I have never heard of that, and I honestly don't believe that is true.

Mr. FRONSTIN. OK. Well, I could certainly check into it.

Chairman JOHNSON. We need to know more about what is driving that.

Mr. FRONSTIN. OK. Another reason that's driving it is that large employers are more likely to offer choice. With choice comes a contribution from the employee. So that automatically builds in this difference.

Chairman JOHNSON. But others have told me that actually in a very small business market, premiums are likely to be shared 50–50, employer-employee. In fact, the Joint Tax Committee estimator believes that there is a very large small business market in which the small business owner offers the plan, but provides no portion of the premium at all. Have you ever seen that?

Mr. FRONSTIN. We haven't looked at that by firm size, but getting to the question that came up in the earlier panel, we have looked at, from the employee side, what percentage report that their employer does not contribute anything. And it's small. I don't have that data with me, but I remember it being——

Chairman JOHNSON. If you could share with us whatever data you have on that subject of how many employers there are out there offering plans but not participating in on the costs, that would be very helpful.

Mr. FRONSTIN. I will.

[The following was subsequently received:]

This is a very important question, one that I (or anyone else) do not have a good answer for. The only nationally representative survey of employers was recently released by the Center for Disease Control, National Center for Health Statistics. They did not report data on employers paying for health insurance. Papers from the 1993 RWJ-Rand Employer Health Insurance Survey also did not include this information. I can tell you that data from the March 1995 CPS indicates that only 6.3 percent of persons ages 18–64 with employment-based health insurance in their own name paid the full cost of their health insurance. Hence, very few workers do not have help. But I would argue that no employers (except maybe those with minimum wage workers that offer health insurance) really pay any of the cost.

Chairman JOHNSON. And if you have the ability to look at that by size, that would be very helpful.

Mr. FRONSTIN. I do. I know it's in the range of 4 to 8 percent, and if my 5-minute memory serves me right, it really hasn't changed over time, whereas the percentage not paying the full cost has significantly eroded.

Mr. KLEIN. Could I amplify on your comment about the pension and health distinction? I think you are absolutely right. Of course, in the pension arena, which is the other half of what our organization does, the nondiscrimination rules are a tremendous impediment to providing coverage. And I know Mr. Portman is working on legislation in that regard and has been, as have you, Madam Chairman, been very attentive to the need to correct those.

I think you are quite right though on the health side. There is a provision of the Tax Code, if I am not mistaken I think it's section 105(h) of the Internal Revenue Code that speaks, I believe, in some general terms that health benefits are not to be provided in a discriminatory fashion. But it has never really been an issue.

I don't really believe Treasury has ever even issued any regulations because that just isn't the way health benefits are provided. In the self-employed context, in fact, it is just the opposite. Self-employed individuals' employees often get the coverage when the entrepreneur doesn't, and in the more general corporate world, everybody from the chief executive officer to the person in the mailroom is covered by the same health plan.

Mr. NELSON. One additional comment. If the 100-percent deductibility didn't help everyone to keep their insurance or others to get it, your bill at least would address the people that didn't have that. If this employer would say, OK, I'm going to give you another $500 a month and you do your own benefits, at least then they could deduct their own premiums that they bought.

Chairman JOHNSON. It would be preferable if the employer would join a plan so that there would be group rates.

Mr. NELSON. Right.

Chairman JOHNSON. And then if we give deductibility, that increases affordability to the more affordable plans in the market to better balance of coverage and affordability. That's a very interesting point to me that you do see that movement in the market toward cash and away from benefits.

I think that's one of the reasons why it's important to begin moving forward and expanding in a more equitable fashion, access to at least the tax deductibility, recognizing that some of the ideas for tax credits in certain sectors and expansion of MSA employer and employee contributions would also be very valuable in expanding access and affordability.

Mr. FRONSTIN. Can I add one more point to this? I also think that small employers are more likely to fully finance it because of minimum participation requirements that the insurer may place on the employer. Because if you're insuring a small employer, you don't want just one person to accept coverage. You want everyone to accept coverage to minimize the risks of adverse selection.

So in order to increase participation, you really have to look at——

Chairman JOHNSON. That is true, and that could be where that came from. That is a problem, and that may be something that we do want to think about this time around.

Mr. Coyne.

Mr. COYNE. Thank you, Madam Chairman. Mr. Fronstin, I know you have done a great deal of research on issues that affect the uninsured, and I'd just like to ask you a couple questions not about your testimony here relative to COBRA.

In 1997, in a report on the uninsured, you concluded that the self-employed are not likely to purchase health insurance in large numbers, even when it is fully deductible. And I just wonder if you have any sense of why that is.

Mr. FRONSTIN. Well, again, I think there are other factors going on besides the deductibility that I mentioned. You have the requirement that an insurer may require you to have minimum participation levels. That's going to cost you more than just buying it for yourself and making it available for your workers.

Mr. COYNE. Your report also mentioned that the number of uninsured children increased between 1995 and 1996, and you attributed the increase to a drop in children receiving Medicaid. Do you think that was because fewer children were eligible or were there some other reasons?

Mr. FRONSTIN. I am not 100-percent sure of the reasons. I believe that is one reason. We really haven't looked at it in great detail to try and figure out exactly what is going on there. But overall, fewer families are eligible for Medicaid, so that is certainly—you know, we have seen that.

But I think we also found that the effect was largest among children that were under the poverty level and under age 6, which would mean that they were eligible for Medicaid anyway. So there is something going on there and we don't really have our hands on it yet.

Mr. COYNE. And you intend to look at it further?

Mr. FRONSTIN. I'd be glad to look at it.

Mr. COYNE. Thank you.

Chairman JOHNSON. Excuse me.

Mr. Portman.

Mr. PORTMAN. Thank you, Madam Chair. First of all, I want to thank Mr. Klein and also Lynn Dudley in your office for working with us on pension simplification. I think there is some overlap here in terms of the issues we are discussing, and I hope we can get something introduced in the next couple of weeks on that to further provide access to retirement savings.

On health care though, in your testimony, you talk about—and Mrs. Johnson raised it earlier—tax expenditures versus government expenditures through public programs. And I think what you are saying, if I read it right, is that in just pure economic terms that tax expenditures are a much more efficient way to pay for so-called uncompensated care.

The numbers that Mrs. Johnson talked about and then the individualized numbers, for every dollar of tax expenditure you get about three dollars and ninety cents' worth of health benefits. I guess one wouldn't want to make a direct comparison there because some of those folks are going to go out and purchase health care even without the subsidy, correct?

Mr. KLEIN. Yes, some would do so.

Mr. PORTMAN. Do you have any sense of what that would be? I mean, to compare the tax expenditure versus what would otherwise be a public expenditure. I know that is difficult to because of the way our health care market works, but do you have any sense of that? Would it be $3 or $2?

Mr. KLEIN. I think it would be very hard to quantify that, since I think the point here was that if this were a burden that would have to be absorbed by government it would be all shelled out by the taxpayers through the Federal coffers. But here, by encouraging a voluntary system, it can be done much more cheaply.

Mr. PORTMAN. I think it's a good point. I was just trying to get a better sense of what the numbers are. I think at some point there is a public policy option which says tax expenditures are more expensive than the public program. And I don't know how far you go.

I mean, you could have a tax credit, I suppose. That would be the richer credit we could provide, or richer benefit we could provide in tax terms. And you could even provide additional incentives to employers. How far you go is, I guess, the question I would have.

Mr. KLEIN. Well, I guess another way of looking at it is that this tax preference is such a crucial part of employer sponsorship of plans, for all the reasons that were demonstrated by witnesses on both panels. While it's true that there would be some people who would go out in the individual market, with or without tax incentives, and buy it, because of the disadvantages of the individual market that we discussed, it would be much more expensive. So that would sort of mitigate the other way in terms of this being less of a bargain.

Mr. PORTMAN. Or the advantages of the pool and the benefits you get from a larger group.

The other issues I have really relate to some of the questions that were raised in the last panel, and that has to do with the differences between Mrs. Johnson's bill and maybe some other proposals out there and how they would relate to one another.

One is long-term care. I don't know if you gentlemen have any thoughts on that. But as I look at the Senate proposal, for instance, I don't see a deduction for long-term care. Is that a critical element of this? Let me ask you this way, is it more important to provide long-term care coverage, given that we have limited resources here; or to provide, let's say, for the 6 million people that Mr. Gradison talked about who are working but who are not taking advantage of the ability to achieve health care through their employer, and to provide for them a deduction even though they are working? Do you see what I am saying? How would you prioritize these?

Mr. KLEIN. I'll leave that to the infinite wisdom of the elected Members of Congress to decide. Fortunately, we are operating more in an era of surpluses than deficits.

Mr. PORTMAN. But even in an era of surpluses, what would be the priorities for you all?

Mr. KLEIN. I think that more employers would like to be able to offer long-term care, and more individuals want to buy it, apropos of the so-called sandwich generation I mentioned before. My children are here today; and my parents are also in the audience, because they happened to be in town as well; and I think that long-term care insurance is something that is very much on the minds of everybody, and it's going to be more so as my generation, the baby-boomer generation, retires.

I think that with all of this, you've got to balance how much money is available. But I think you also have to come to the conclusion, as a matter of policy, that this is a tax expenditure that is worth it, both to extend vital basic coverage to individuals who are uncovered, as well as long-term care, which is clearly going to be a form of coverage which is going to only grow in importance.

Mr. PORTMAN. Any thoughts on that?

Mr. FRONSTIN. Yes, I would add that in terms of setting priorities I think, if you have to set priorities, you need to look at what the impact is going to be. Certainly people are more focused on health insurance and going to the doctor today and getting into an accident tomorrow than they are about long-term care, which may be 30 or 40 years away for some people. And at the same time, they may be thinking that it is something they hope to never use even if they eventually buy it.

But certainly, giving it the tax preference would raise awareness and increase education, which is what I think we need with long-term care insurance.

Mr. PORTMAN. And given the Federal role in all this, there is also perhaps an interest from our point of view as policymakers trying to determine all these priorities, that might be something that is a little more urgent than it would be for someone in his or her thirties thinking about long-term care.

Mr. FRONSTIN. Absolutely.

Mr. PORTMAN. Because of the demographic shift and the problems we've got with Medicare and so on. Mr. Nelson, any thoughts on that? Most of your folks probably are in the self-employed category, and would like to see the 100-percent deduction immediately.

Mr. NELSON. Right. That would be our priority.

Mr. PORTMAN. Is long-term care a big priority?

Mr. NELSON. I'd point out that I can't quantify as to how large a priority, but it's certainly on our list and we've certainly discussed it. The important thing, I think, to look at is how much cheaper it is to purchase long-term care as you are younger, of course.

And so in the incentives, there is a balance there somewhere, where you get a deduction where you would have people buying long-term care younger and then probably spending the same money or less money than they would if they waited until they were 60 years old and a very high premium.

Mr. PORTMAN. So it could be a public policy goal to provide some encouragement early on to do that.

Mr. NELSON. Right.

Mr. PORTMAN. Well, thank you very much. There are lots of other questions, but again, I really appreciate the input. I think it's very timely. I think Congress may be poised to do something in the tax area with regard to accessibility.

Mr. KLEIN. And Mr. Portman and Madam Chairman, if you could just indulge for one moment. Thank you for the kind words on APPWP's efforts on the pension matter. I have found over the years that there are many Members of Congress who are often willing to be out front on health care issues; very few on pension issues. And the Chairman is certainly one of them, and you have become certainly one of them as well with your effort on these matters. And we thank you for that.

Chairman JOHNSON. We will be holding a hearing on that matter in the months ahead, and at that hearing we hope to get a better grasp of how much SIMPLE has simplified things and how much difference it has made, and whether SAFE and whether all of the ideas that Rob has for simplifying the small business pension world. This is really terribly important.

Karen.

Mrs. THURMAN. Thank you, Madam Chairman. Let me ask a question. Is there any concern from any of you if the tax deduction were put into place, that it could potentially increase premiums? And I'll give you the idea that we hear sometimes, if we give tax deductions for education that tuition will rise because you can get away with it.

Do you feel that could happen at all? I didn't mean to do the hard question in front of your kids.

Mr. KLEIN. I suppose it could work that way. Health economics sometimes works in perverse ways, from other kinds of goods and services. But I guess I would probably disagree, because I would think that the deductibility would enable more people to go out and obtain it in a much more efficient way than the kinds of uncompensated care that we have now that are shifted either to other purchasers in the system like my members, for example, or to public programs, be they Federal, State, or municipal. That is a lot of wastefulness.

And so whatever economic effect might occur by making those deductible would hopefully be more than offset by this more efficient purchase. And that people also wouldn't be therefore having to wait as long to get into the health care system, because that's another problem of the uninsured, and their costs would be lower.

Mr. FRONSTIN. Certainly, if you are bringing in more healthy people, it will either reduce rates, because you are going to have a less adverse group or rates won't go up as fast. So the opposite effect may happen. There may be additional competition to enroll these people.

Mrs. THURMAN. With that answer in mind, though, let me ask you this, because I've got a chart up here that just talks about taxable income for married, joint filers if they were making zero to $42,000, their average insurance was $5,600 and their tax benefit would be about $840. So their net insurance cost would be about $4,760.

If you went down to, say, $100,000 to $155,000 for taxable, their tax benefit would be about $1,736, and then it would be about $3,864, assuming it would still be $5,600. So the real issue here is—and I don't disagree with you, because I think we see it in the Medicare Program, I think we've seen it in others—that we can get into this group, and the more people we have to spread our risk over, the lower our costs become.

So if we did this tax incentive, that's still only going to pick up a small portion. I don't see it picking up—I don't know what the number is, but whatever. But you're still looking at that, even from zero to $42,000, of only getting the tax benefit of $840, it still costs them $4,700. If they have two children, trying to buy a house, have two cars, I don't know where they get the money to pay for that.

So help me. Is there something else Congress can do besides just a tax incentive to get other people into these programs?

Mr. KLEIN. Yes. The tax incentive that is contained in the Chairman's bill will certainly help address a component piece of that 40 million uninsured.

Mrs. THURMAN. How many is that, do you know?

Mr. KLEIN. I don't know that that's been done.

Chairman JOHNSON. Unfortunately, but truthfully, most of the data we have is 10 years old. We are having a very hard time getting the data. And then the other thing that is a component in this is the variability of costs.

Now, for instance, the premium costs that you gave are probably specific to your State. There are other figures that, for instance, if somebody in this category wants to buy a high deductible, then their actual deduction could be quite considerable relative to their premium.

I think one of the things that's been made a lot clearer to me today in this hearing is that if we can get more small employers to offer coverage to their employees because they are going to benefit, that we might have a bigger impact that way.

So there is an equity argument here that's quite powerful. I mean, all those who are currently paying ought to have the right to deduct.

And then there is an expansion argument that really varies according to State cost, that will vary according to how many small employers come into the whole sector, and then will vary as to how many of that 28-percentile income bracket actually use this as an incentive.

But you're right. This doesn't solve the whole problem. Exactly how much it does solve, we are really having a hard time figuring that out.

Mr. KLEIN. Right. If I may answer the question——

Mrs. THURMAN. Let me ask Dr. Fronstin, because some of this is actually based from his, that was a nonelderly population with selected sources of health insurances by family income. I believe this is the report generated by you.

Mr. FRONSTIN. Yes.

Mrs. THURMAN. That gives us kind of an average, but we've got to have some idea of potential amount of people. I mean, I'm not saying that everybody would take advantage of it anyway, but say within a selected amount of that lower income, how many people—or reverse that, those people in more of a middle income who potentially would benefit, who might go ahead and take this, who might get a benefit of $1,700, $1,800.

How many people would we be talking about there? Because if we can get those folks in, the benefit to the whole program is that it brings more people in which should then bring the cost down for everybody so we could encourage more people to get in. Right?

Mr. FRONSTIN. Yes. I don't want to pick a number from there, because it would really be impossible just to look at the tables we present in this paper and pick a number. But getting back to your point about income levels, aside from the fact that low income are less likely to pay taxes, so there may be a lower benefit. If they were paying taxes, if they're in a 15-percent tax bracket and they're only getting an $800 benefit compared to someone who's making $100,000 or more, that $800 may be more valuable to them than someone who is making $100,000.

Mrs. THURMAN. Maybe more valuable, but their cost doesn't change. The cost is still the same.

Mr. FRONSTIN. That's right. But at least as far as health insurance goes, that higher income person probably already has it.

Mrs. THURMAN. Well, that's part of the problem too. They already are affording it and so that's a problem, and I understand all that. I'm just trying to figure out—I mean, I have no problem and have voted several times. I think it's a wonderful idea to give tax deductions for small businesses. I think it's a great idea.

But quite frankly, we've done that. I mean, I know we're not to the full 100 percent. The problem is for everybody's benefit, we've got to have that incentive to bring people in, and that's what we've got to look for.

Mr. KLEIN. Yes, and you asked the question, which I apologize for not directly answering when I gave the first response, and that is what else might Congress do in addition to this deductibility, since we all concede that it won't solve the entire problem.

I would suggest three things. And first, since we are talking about health care, I would suggest that Congress take a page from the Hippocratic oath and first, do no harm, and I refer back to the comments in my testimony about the problem of mandates and the problem of adding cost.

Mrs. THURMAN. I don't disagree.

Mr. KLEIN. The second thing, on a more positive note, I suppose, would be to extend the current ERISA preemption to do away with a lot of those State-mandated benefits that have also added such tremendous costs on the fully insured market. Not to interfere with the States' regulatory authority over the health insurance marketplace or those matters, but rather to preempt, as ERISA preempts at the Federal level for self-insured companies, the opportunity for those State legislatures to enact the—what is it now—900 various State mandates.

And I guess maybe the third thing that Congress might suggest doing, is a little bit more of a philosophical answer. And that is that government might decide to lead by example. The Federal Government is the largest purchaser of health care in this country, both on behalf of its employees, certainly, but also for the public programs for which the government is essentially the plan sponsor.

And government should really use its position, I think, as the Nation's largest purchaser, not in some grand regulatory scheme, but rather to lead by example and not to be catching up with the private sector in terms of advances in managed care, for example, but really to be leading. I think that some of the steps that have been taken, certainly in Medicare last year, have led in that direction and that's very positive. And there's a lot more of that to do.

So maybe it involves your pressing public policies as they relate to Medicare and other publicly financed programs; and also directives to the Office of Personnel Management in its role as the purchaser for Federal employees to do those kinds of positive things.

Mrs. THURMAN. Some of that would be taken care of by the marketplace, and I know Nancy probably agrees that in some of our rule areas, we can't even get managed care into some of those areas. So you can talk about them all day and set them by example, but if we can't get people and get competition in there, we are still at the mercy of whatever is available. And sometimes there's nothing but fee-for-service.

Mr. NELSON. And that's going to continue. I mean, it might change a little in the future, but we still have to recognize that there is going to have to be a substantial fee-for-service system in the rural areas.

MSAs might be one way that we would like to see——

Mrs. THURMAN. If you had that kind of money to set aside.

Mr. NELSON. Right. That's true.

Mrs. THURMAN. But reimbursement rates to managed plans at a more equitable as versus what we're seeing, even though we're getting ready to go into somewhat of a——

Mr. NELSON. It's been started, but it needs to be evened out a little bit.

Mrs. THURMAN. It's got a long way to go.

Mr. NELSON. It's still not very even.

Mrs. THURMAN. That's right.

Chairman JOHNSON. Thank you very much for your testimony. And in conclusion, some of you, as in the preceding panel, represent significant research capability. We really need your help in trying to look at the uninsured people who are in the 28-percent bracket, and you have to do this State specific. National averages don't give us a lot of help. Looking at the market State by State, what's the cost of various insurance plans that would be available to people? What would a 28-percent incentive look like? And what kinds of plans would enable people to buy? What premium subsidy would it offer for a high deductible for a modest plan, for a high-cost plan?

Also, what is going to be the effect of CHIP, of the plan that will cover all children? And again, this sort of has to be State by State, because while CHIP goes up to 200 percent of poverty income, in Connecticut it's going up to 300 percent of poverty income.

And anybody thereafter is going to have the right to buy health insurance for their children at $40 a month if their employer doesn't offer it. It's still a small business benefit.

But can you help us see what dimensions of incentives this would provide, because I believe for the 77 percent over 28 percent, who are in the 28-percent category, looking at the prices of insurance in that market, this is going to be significant. Could you also help us look at how many very small employers there are who don't have the right to deduct 100 percent of premium for their employer, and therefore, if they had that right, might get into this market.

My friend, Mr. Portman, never ceases to amaze me in the questions he comes up with. His question about long-term care insurance was very relevant. The estimate on this bill shot up when we included long-term care. I couldn't believe it.

So I can tell you roughly, though, from work years ago, a couple of years ago, that I wanted to see what would happen if we reduced the employer deduction from 100 percent down to whatever, so that everybody would get the same. And I can tell you it dropped about 18 points down to about 82 percent if you included long-term care insurance and Medigap insurance deductibility.

There is a terrible inequity in our structure, and we do have to put some first things first. And if you can help us look at the number of small employers who don't under current law get to deduct 100 percent, that gives us some sense of how many employees might gain access if we went immediately to 100 percent, at least for self-employed people who employed other people.

So if you can help us slice this up to look at where do we get the greatest incentive right now for health care coverage. The employer market and the 28-percent market do indicate that there is some significant opportunity to expand coverage, as well as to correct an absolutely horrendous equity issue where you have low-income families, many of them struggling to carry health insurance because they have a child with some illness and not getting a penny of deductibility.

We will be moving forward. My bill doesn't represent necessarily the shape of final action. There are other ideas on the table. And then there will be a limited number of dollars available.

I really urge you to use your research capabilities to give us suggestions or comments on questions that I've raised, because we need to move forward in the next couple of weeks with better data than we have now.

Thank you very much for participating, and anyone in the audience who would like to offer data-based ideas, please feel welcome to do so. Thank you very much.

Mrs. THURMAN. Madam Chairman.

Chairman JOHNSON. Sorry.

Mrs. THURMAN. Mr. Coyne had asked, if it's agreeable with you, if I could request unanimous consent that the following two documents would be included in the Oversight Subcommittee's hearing record.

Chairman JOHNSON. Of course.

Mrs. THURMAN. The first one is the Health Insurance Reform Project, which was sponsored by George Washington University with support from the Robert Wood Johnson Foundation, and the second is the recent report commissioned by the AFL–CIO concerning the impact of employer cost shifting and other economic factors on the erosion of employer-provided health insurance coverage.

Chairman JOHNSON. Absolutely.

Mrs. THURMAN. Thank you very much.

[The inserts are being held in the Committee files.]

[The following questions submitted by Chairman Johnson and Mr. Fronstin's responses are as follows:]

Q. What is the variation in the amount employers contribute to health plans? (I am looking for a break down in either numbers or percentages of employers, if possible. I already have data showing that most employers contribute between 70–80%.)

There is no one answer here. A recent survey from William M. Mercer, a benefits consulting firm found the following for the employee contribution in 1997 (the employer contribution would be 100 minus the numbers below):

indemnity plan
  employee-only 24%
  family 32%
hmo
  employee-only 23%
  family 34%
PPO
  employee-only 23%
  family 36%
POS
  employee-only 22%
  family 31%

Note: these numbers have been virtually unchanged since 1993.

Q. How many employers do not offer coverage for the employees' dependents?

This is another question that I cannot answer from the employer perspective. I can answer it from the employee perspective but the data is old. According to data from the April 1993 Current Population Survey, only 6.4 percent of wage and salary workers with employment-based health insurance were only offered employee-only coverage.

Q. How many of the employees who do not have employer-subsidized coverage have incomes high enough to purchase health insurance on their own? (You may not have data to support that kind of determination, but it would at least be helpful to know the incomes of employees without employer-subsidized health coverage.)

I'd like to follow-up with you on this one. In order for me to do that I need to know if you want 1. all workers without employment-based coverage. 2. all workers without employment-based coverage through their own employer (marital status complicates this picture because you can be working with employment-based coverage through your spouse) 3. uninsured workers.

Q. Is it realistic to assume that an employee who declines employer-sponsored health coverage can get the potential employer's contribution back in cash wages?

Yes and no. Some employers will, some won't. However, if you assume that more and more of the cost is being shifted onto workers, then when they decline coverage they effectively get the cash wages because they are already part of salary.

Chairman JOHNSON. Thank you.

[Whereupon, at 3:29 p.m., the hearing was adjourned subject to the call of the Chair.]

[Submissions for the record follow:]

Statement of Hon. Jim McDermott, a Representative in Congress from the State of Washington

As a physician, I have found it quite difficult to understand why Congress has done so little to address the health care needs of the tens of millions of uninsured and underinsured Americans over the past 4 years. As a psychiatrist, I find it very difficult to comprehend the schizophrenic way in which this Committee has chosen, or not chosen, to address the issue of health care tax incentives.

I have devoted my time in Congress to promoting efforts to guarantee universal health coverage to all Americans. I have also attempted several times in this Committee and on the floor of the House to both increase the self-employed health care tax deduction and create a health care tax credit for the working uninsured. Each time that I have offered these proposals the Republican Majority—including many of the people here today—has voted to kill those efforts. So I have great difficulty taking this election-year hearing seriously beyond it's supposed public relations value.

However, in the slim chance that the Majority is sincere about improving the affordability of health care coverage for all Americans, I would like to describe alternative legislation which I support.

Early last year I reintroduced H.R. 539, legislation which will give working Americans who are not provided health insurance by their employer a refundable tax credit worth 30% of the cost of their health insurance premiums. Although the credit would be refundable, it could not exceed the amount the employee actually paid in income and payroll taxes.

The 30% tax credit will begin to phase-out for individuals earning more than $25,000 and for families earning $40,000 or more. These income levels will also target the benefit to the lower and middle income working Americans who comprise almost 80% of the nonelderly uninsured.

To guard against the possibilities of tax fraud, a payment for health insurance may be eligible for the credit only if it is substantiated in such form as the Secretary of the Treasury directs.

This legislation is important because it will begin to equalize the tax treatment of health insurance costs for all working Americans. Under current law, if an employee receives health insurance through his employer, and the employer pays part or all of the employee's health insurance premium costs, that benefit is not included in calculating the employee's taxable income. Similarly, a self-employed person is currently able to deduct 45% of the cost of his or her health insurance premiums. Under the recently enacted Health Balanced Budget Act of 1997, this percentage will reach 100% in 2007. Once again, the tax code is providing a subsidy for the cost of health insurance by allowing a self-employed individual to deduct a percentage of the cost of health insurance resulting in lower taxable income.

There is only one group of working Americans who receive no subsidy through the tax code for their health insurance costs—-working Americans whose employers provide no health benefits. The BBA has worsened this inequitable situation. Why should a doctor or attorney who is self-employed be able to deduct a portion of the cost of his/her health insurance, while a secretary, who must buy his/her own health insurance policy, not be able to deduct one cent of the cost?

It is simply not fair for the tax code to grant certain classes of employees preferential treatment when it comes to the cost of health insurance. Cost is still the primary reason people are uninsured.

I am skeptical that a straight deduction, like the one proposed by the Chairperson (H.R. 3475), will make any difference in the affordability of health coverage for the working uninsured. I looked at that option earlier this year and found that we cannot escape the following facts:

- Most uninsured are in the lowest income tax bracket;
- Most uninsured would be helped very little by an income tax deduction for health insurance costs;
- The cost insurance would remain prohibitive for most of these families; and
- For the few uninsured in upper income tax brackets, a deduction for their health insurance costs would be very attractive.

While I'm encouraged that the Majority is finally willing to admit there is a problem with inequity in the tax code when it comes to health care, a deduction merely pays lip-service to the problem. If you want to make a difference, a targetted tax credit, such as the one I propose, will help make health insurance affordable for those employees who have to pay their way.

Statement of Society for Human Resource Management, Alexandria, Virginia

Madam Chair and Members of the Subcommittee on Oversight, thank you for the opportunity to express the views of the Society for Human Resource Management. The Society for Human Resource Management (SHRM) is the leading voice of the human resource profession. SHRM, which celebrates its 50th anniversary in 1998, provides education and information services, conferences and seminars, government and media representation, online services and publications to more than 95,000 professional and student members through out the world. The Society, the world's largest human resource management association, is a founding member of the North American Human Resource Management Association and a founding member and Secretariat of the World Federation of Personnel Management Associations (WFPMA).

We are strong supporters of initiatives that make health care more affordable, thus lowering the numbers of uninsured. Madam Chair, your bill, H.R. 3475, which allows for the full deduction of health premiums for those individuals without employment based health care coverage ensures greater tax equity for the self employed and others. We applaud your efforts as well as those of Chairman Archer.

We support his ideas to create new tax breaks for those purchasing long-term care insurance and creating tax incentives for small businesses to purchase health insurance for their employees.

Although we are clearly concerned about the numbers of individuals without healthcare coverage, we are proud of the contributions employers have made to increase the numbers of individuals covered by employer sponsored plans. In addition, Congress greatly contributed to these efforts by passing the Employee Retirement Income Security Act (ERISA) of 1974 which helped facilitate employer-sponsored plans to cover many more employees. However, legislation has to be carefully crafted in order to provide incentives and not create mandates which would only drive up costs and increase the number of uninsured.

Another ongoing area of concern for human resource professionals is the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The goal of the legislation was to provide employees and their families with temporary healthcare coverage when an employee is between jobs. However, it was passed without Congressional hearings and has been administratively difficult and costly for employers. The premiums collected from the beneficiaries do not cover the costs of the healthcare services because of adverse selection and it is very expensive to administer. Also, the noncompliance penalties are unusually high. President Clinton in his State of the Union address advocated a proposal that would mandate COBRA coverage to retirees that are no longer covered by retiree health benefits. The retiree would be allowed COBRA coverage for up to ten years. Clearly, this type of mandate would force many employers to stop providing healthcare coverage and we strongly oppose this proposal.

Employers offer healthcare benefits because it is good business. Companies compete for and work to retain the very best employees we can, we realize that high quality healthcare coverage is one of the tools we have to attract and keep highly skilled and motivated employees. We want and need for our employees to be healthy. The employer-sponsored system also addresses some of the problems associated with individuals purchasing health care independently, such as adverse risk selection, group purchasing power, and higher administrative costs. In fact, the Congressional Research Service estimated that an individual health policy is 30 percent higher than a group health policy due to administrative costs.

Health care cost inflation has been a problem for employer-sponsored plans and is a major factor in the changing nature of our health care system, from fee for service to managed care. In 1960, health expenditures accounted for close to 5 percent of Gross Domestic Product. In 1996, it jumped to 14 percent of the GDP. However, costs are now being contained and we have a stronger and more accessible healthcare system. We urge you and the Subcommittees to support allowing the market to make any needed corrections rather than destroying the progress we have made by mandating certain benefits. As was stated, mandates simply increase costs and lead to more uninsured.

However, our workforce is changing. We have many more independent contractors, temporary employees and consultants than we did just a few years ago. We need to keep the employer-sponsored healthcare system strong, but we must also work to strengthen the individual health insurance market.

We believe your legislation is an important step in the right direction. The self employed and others who pay for their own health insurance should get the same deduction, not a partial deduction, for health insurance premiums. In addition, continuing the current deduction for employer-sponsored plans is critical to maintaining the strength of the system.

We look forward to working with you as you address the issue of the deductibility of health benefits for the self employed, small business owners and others who do not have employer provided healthcare coverage. In addition, we would like to work with you to strengthen the employer provided healthcare market and provide healthcare incentives through the tax code.